STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09/14/2022			ETED	
	PROVIDER OR SUPPLIE		36 \	EET ADDRESS, CITY, STATE, ZIF VALLEY DR VRENCEBURG, IN 47025		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO TH	SHOULD BE	(X5) COMPLETION
TAG E 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE		DATE
Bldg	conducted by the In accordance with 42 Survey Date: 09/1 Facility Number: 09/1 Provider Number: AIM Number: 100 At this Life Safety Center was found in Emergency Preparameter and Medicare and Medicare and Suppliers, 42 0	4/22 000304 155525 0266810 Code survey, Shady Nook Care in substantial compliance with edness Requirements for icaid Participating Providers CFR 483.73 certified beds. At the time of	E 0000			
E 0018 SS=C Bldg	403.748(b)(2), 41 and (v), 441.184(483.475(b)(2), 48 485.920(b)(1), 48 Procedures for Tr §403.748(b)(2), § (ii) and (v), §441. §482.15(b)(2), §4 §485.625(b)(2), §4 (1), §494.62(b)(1 [(b) Policies and preparedness polion the emergency	6.54(b)(1), 418.113(b)(6)(ii) b)(2), 482.15(b)(2), i3.73(b)(2), 485.625(b)(2), i6.360(b)(1), 494.62(b)(1) racking of Staff and Patients i416.54(b)(1), §418.113(b)(6) 184(b)(2), §460.84(b)(2), i83.73(b)(2), §483.475(b)(2), i485.920(b)(1), §486.360(b) b). corocedures. The [facilities] d implement emergency licies and procedures, based by plan set forth in paragraph gright, risk assessment at				

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

(X6) DATE

TITLE

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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	NT OF DEFICIENCIES OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE DENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/14/2022
	PROVIDER OR SUPPLIE		36 VAL	ADDRESS, CITY, STATE, ZIF LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE COMPLETION
	paragraph (a)(1) communication p section. The polic reviewed and upo [annually for LTC the policies and p the following:] [(2) or (1)] A syst	of this section, and the lan at paragraph (c) of this sies and procedures must be dated at least every 2 years facilities]. At a minimum, procedures must address em to track the location of sheltered patients in the			
	[facility's] care du on-duty staff and relocated during must document to	ring an emergency. If sheltered patients are the emergency, the [facility] he specific name and ceiving facility or other			
	§483.73(b), ICF/I §460.84(b):] Police system to track the and sheltered resolution of PACE] emergency. If or residents are relocemergency, the [PACE] must document	441.184(b), LTC at IDs at §483.475(b), PACE at cies and procedures. (2) A ne location of on-duty staff sidents in the [PRTF's, LTC, care during and after an n-duty staff and sheltered becated during the PRTF's, LTC, ICF/IID or cument the specific name e receiving facility or other			
	Policies and proc (ii) Safe evacuati includes consider needs of evacued transportation; id- location(s) and pro- of communication assistance.	pospice at §418.113(b)(6):] redures. on from the hospice, which ration of care and treatment res; staff responsibilities; rentification of evacuation rimary and alternate means rewith external sources of rack the location of hospice			

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	OF CORRECTION	IDENTIFICATION NUMBER 155525	A. BUILDING B. WING		COMPLETED 09/14/2022
	PROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 hospice's care the on-duty emplo are relocated durir hospice must docuand location of the location.	ty and sheltered patients in during an emergency. If yees or sheltered patients and the emergency, the ument the specific name receiving facility or other 485.920(b):] Policies and			
	CMHC, which incli and treatment nee responsibilities; tra of evacuation loca	afe evacuation from the udes consideration of care ads of evacuees; staff ansportation; identification tion(s); and primary and f communication with assistance.			
	procedures. (2) A documentation tha actual donor inforr confidentiality of p	at preserves potential and mation, protects otential and actual donor ecures and maintains the			
	procedures. (2) Sa dialysis facility, wheresponsibilities, are Based on record reversible to ensure emergency and procedures include to ensure emergency. If on-dures idents are relocated to the LTC facility must describe to the receive in accordance with a dialogation of the receivers.	94.62(b):] Policies and afe evacuation from the nich includes staff and needs of the patients. The area and interview, the facility ergency preparedness policies and a system to track the staff and sheltered residents a care during and after an arty staff and sheltered red during the emergency, the occument the specific name and ving facility or other location 42 CFR 483.73(b) (2). This could affect all occupants.	E 0018	The plan of correction constituthe written allegation of compliance for the deficienciecited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of corrections submitted to meet requirement established by state and feder law. Attached for your review and several submitted to make the several submitted to meet requirement established by state and feder law. Attached for your review and several submitted to make the several submitted to meet requirement established by state and feder law. Attached for your review and several submitted to make the several submitted to meet requirement established by state and feder law.	s this on is t al

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING COMPLI B. WING 09/14/2			ETED	
	PROVIDER OR SUPPLIEF		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIAL DEFICIENCY)		(X5) COMPLETION DATE
	plan on 09/14/22 be with the Director of Administrator present that include a system on-duty staff and she facility's care during available for review time of record review there was no system on-duty staff and shof an emergency in	ent, no policies and procedures on to track the location of neltered residents in the LTC g and after an emergency was r. Based on interview at the ew, the Administrator confirmed on to track the location of neltered residents in the event		approval, is the completed pla correction for the recent Life a Safety Code Survey, Event ID 5IVX21, conducted on Septem 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective Octobe 2022. Shadynook Care Center also respectfully requests a dereview for this plan of correction the location of on-duty staff and sheltered patients in Shadynook Care. What corrective action will be accomplished for those reside found to be affected by the deficient practice? All residents have the potential be affected by the alleged defining practice. The Shadynook disamplan has been revised to incluran emergency plan for transfershelter of on-duty staff and sheltered residents. The disamplan also includes the Skilled Nursing Care Evacuation procedure; including tracking conduty staff and residents. (Sattachment of Emergency Preparedness Plan, Page 10; 7 and Page 12.	end nber at it of er 3. r esk on. Care track nd ok's ents ents eter de er and eter	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155525	A. B	JILDING ING		COMPL	
		100020	B. W			09/14/	ZUZZ
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
SHVUAN	NOOK CARE CENT	ER			LEY DR ENCEBURG, IN 47025		
	NOOK CARE CENT	EN		LAWRE	- NOEDURG, IIN 4/020		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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 OR	LISC IDENTIFYING INFORMATION	+	TAG	How other residents have the		DATE
					potential to be affected by the		
					same deficient practice will be		
					identified and what corrective		
					action will be taken?		
					All residents have the potentia	ıl to	
					be affected by the alleged def		
					practice. The corrective action		
					the deficient practice included		
					revision of the disaster plan to		
					include the emergency plan for transfer and shelter of on-duty		
					and sheltered residents, track		
					of on-duty staff and residents,	-	
					well as the Skilled Nursing Ca		
					evacuation procedure.		
					What measures will be put into		
					place and what systemic chan	-	
					will be made to ensure that the		
					deficient practice does not rec The staff were educated on th		
					revised policy before or by	C	
					September 30, 2022. (Attachn	nent	
					B) All new employees will und		
					training during general orienta	-	
					and ongoing in-services, as		
					dictated by the facility, which	will	
					include the language of the re	vised	
					disaster plan.		
					Llow will the commenting and the m	ha	
					How will the corrective action monitored to ensure the defici		
					practice will not recur?	GIIL	
					The corrective action will be		
					monitored by the Administrato	r or	
					designee. Any areas of conce		
					will be brought to the QA		
					committee for review. And		
					emergency preparedness will	be	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	LETED
		155525	B. W	ING		09/14	/2022
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	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
E 0024 SS=C Bldg	441.184(b)(6), 484 483.73(b)(6), 484 485.68(b)(4), 485 491.12(b)(4), 494 Policies/Procedu §403.748(b)(6), §441.184(b)(6), §483.73(b)(6), §485.68(b)(4), §485.920(b)(5), §6485.920(b)(5), §6485.92	res-Volunteers and Staffing §416.54(b)(5), §418.113(b)(4), §460.84(b)(7), §482.15(b)(6), 483.475(b)(6), §484.102(b)(5), 485.625(b)(6), §485.727(b)(4), §491.12(b)(4), §494.62(b)(5). procedures. The [facilities] d implement emergency licies and procedures, based by plan set forth in paragraph in, risk assessment at of this section, and the plan at paragraph (c) of this icies and procedures must updated at least every 2 for LTC facilities]. At a licies and procedures must wing:] (7) as noted above] The use an emergency or other ing strategies, including the for integration of State and			reviewed at least annually ar more often if indicated.	ıd	

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emergency and other emergency staffing strategies to address surge needs during an

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPI 09/14	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIAL DEFICIENCY)	ATE	(X5) COMPLETION DATE
	procedures. (4) Temployees in an emergency staffin process and role of Federally designal professionals to a an emergency. Based on record refailed to ensure emand procedures including integration of State care professionals to an emergency or ot strategies, including integration of State care professionals to an emergency in act 483.73(b)(6). This all occupants. Findings include: Based on review of plan on 09/14/22 be with the Director of Administrator present address the use of verification of the standard of the sta	view and interview, the facility ergency preparedness policies lude the use of volunteers in her emergency staffing g the process and role for or Federally designated health o address surge needs during cordance with 42 CFR deficient practice could affect The Emergency Preparedness etween 10:00 a.m. and 1:15 p.m.	E 0	024	The plan of correction constitute the written allegation of compliance for the deficiencie cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correcti submitted to meet requirement established by state and feder law. Attached for your review approval, is the completed plat correction for the recent Life at Safety Code Survey, Event ID 5IVX21, conducted on Septem 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective Octobe 2022. Shadynook Care Center also respectfully requests a direview for this plan of correction E 0024 It is the policy of Shadynook Care Center to ha procedures for use of volunted an emergency or other emerging strategy. What corrective action will be	on is on it or on is on it of one of it of one on is on it on it of one one on it of one one on it of one one on it of one	09/30/2022

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/14/2022	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
SHADY N	NOOK CARE CENT	ER			LEY DR ENCEBURG, IN 47025		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					accomplished for those resider found to be affected by the deficient practice? No residents were affected by alleged deficient practice. A property and procedure have been developed that addresses the of volunteers, staffing strategic including the process and role integration of State and federal designated health care professionals and to address surge needs during an emerge (See attachment of Emergency Preparedness Plan, Page 8; It 19 and Page 9; Item 1 and 8.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential be affected by the alleged defipractice. The corrective action this deficient practice included reviewing/revising the disaster to include a plan for use of volunteers, staffing strategies, integration of state/federal agencies during an emergency and/or during surge emergency and/or d	the olicy use es, e of al ency. ey tem for l r plan y y y o nges e e nent	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 09/14/2022			
	PROVIDER OR SUPPLIE			36 VALI	ADDRESS, CITY, STATE, ZIP COD LEY DR NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					training during general oriental and ongoing in-services, as dictated by facility, which will include the language of the redisaster plan. How will the corrective action monitored to ensure the deficit practice will not recur? The corrective action will be monitored by the administrato designee.	vised be ent	
E 0035 SS=C Bldg	§483.73(c)(8); §4 *[For LTC Facilities [(c) The LTC facilities maintain an emeron communication possible for the possible fo	Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):] ity must develop and gency preparedness lan that complies with d local laws and must be lated at least annually. The lan must include all of the					
	emergency preparation plan that complied local laws and must least every 2 yields plan must include (8) A method for emergency plan, determined is appropriate the complex of the complex	redness communication s with Federal, State and ust be reviewed and updated ears. The communication e all of the following:] sharing information from the that the facility has propriate, with residents [or families or representatives.					
	Based on record re lacked an emergen	view and interview, the facility	E 003	5	The plan of correction constitute the written allegation of compliance for the deficiencie		09/30/2022

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 1/2022
	PROVIDER OR SUPPLIER		36 VAI	ADDRESS, CITY, STATE, ZIP C LLEY DR ENCEBURG, IN 47025	COD	
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	residents and their faccordance with 42 deficient practice of Findings include: Based on review of plan on 09/14/22 be with the Director of Administrator preservation and the emergency plan determined is approfamilies or represer the time of record reconfirmed the document of the document of the document of the time of record reconfirmed the document of the document of the time of record reconfirmed the document of the docume	R LSC IDENTIFYING INFORMATION tion from the emergency plan determined is appropriate with families or representatives in CFR 483.73(c)(8). This ould affect all occupants. The Emergency Preparedness etween 10:00 a.m. and 1:15 p.m. f Maintenance and		cited. However, submit plan of correction is not admission that the defective exists or that one was correctly. This plan of submitted to meet requestablished by state at law. Attached for your approval, is the complication for the recessafety Code Survey, ESIVX21, conducted on 14, 2022 at Shadynoo Center. Please be advis our intent to have the correction also serve a allegation of compliance compliance is effective 2022. Shadynook Care also respectfully requereview for this plan of E0035. It is the policy of Shade Center to develop and emergency preparedneon communication plan the with the Federal and Slocal laws. What corrective action accomplished for tho	ission of this of an iciency cited correction is uirement and federal review and eted plan of an Life and Event ID a September k Care vised that it is plan of as our ce. e October 3. e Center ests a desk correction. dynook Care maintain an ess and complies State and on will be	
				residents found to be by the deficient pract No residents were affer alleged deficient praction and procedure have be developed that ensure and representatives we communicated with in an emergency. Information	ected by the ected	
				included in the admiss		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED
		155525	B. W	NG		09/14/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R			LEY DR	
SHADY I	NOOK CARE CEN	TER			ENCEBURG, IN 47025	
WA ID	CVP O () DV	COLUMN OF PERIODICAL			T	(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	·	NCY MUST BE PRECEDED BY FULL BLSC IDENTIFYING DIFFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	+	TAG	to ensure each new resident,	
					family, and/or representative i	
					aware of the Emergency	3
					Preparedness plan and how the	hie
					facility will ensure their safety	
					during an emergency.	
					(See Attachment in Emergen	ncv
					Preparedness Page 9; Item 1	- I
					and Page 10; Item 3 and 6)	
					How other residents have th	e
					potential to be affected by the	
					same deficient practice will I	
					identified and what corrective	III
					action will be taken?	
					All residents have the potentia	al to
					be affected by the alleged def	
					practice. The corrective action	
					this deficient practice included	1
					information added to the	
					admission packet to ensure ea	ach
					new resident, their family and	/or
					representative is aware of the	
					Emergency Preparedness pla	n
					and how this facility will ensur	e
					safety during an emergency.	
					What measures will be put in	nto
					place and what systemic	
					changes will be made to	
					ensure that the deficient	
					practice does not recur?	
					The Administrator or his/her	
					designee will ensure that each	
					current and new resident rece	
					proper education. Any variance	
					will be tracked and trended ar	
					reported to the QAPI committee	
					How will the corrective actio	n
					be monitored to ensure the	
					deficient practice will not	
I	1				recur?	

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		IDENTIFICATION NUMBER 155525		JILDING	INSTRUCTION	COMPLETED 09/14/2022	
	ROVIDER OR SUPPLIER			36 VALI	ADDRESS, CITY, STATE, ZIP COD LEY DR NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	Ē	(X5) COMPLETION DATE
K 0000 Bldg. 01	Licensure Survey w Department of Health 483.90(a). Survey Date: 09/14 Facility Number: 00 Provider Number: 1002 At this Life Safety Conter was found not Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupation of the Saf	200304 155525 266810 Code survey, Shady Nook Care of in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ation Association (NFPA) 101, SC), Chapter 19, Existing and 410 IAC 16.2.	K 0	000	The corrective action will be monitored by the Administrator designee.	or	

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039			
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X)	(3) DATE SURVEY COMPLETED 09/14/2022			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K 0200 SS=D Bldg. 01	were sprinkled and services were sprin Quality Review con NFPA 101 Means of Egress Means of Egress List in the REMAR Section 18.2 and requirements that provided K-tags, I information, along Safety Code or N should be include 18.2, 19.2 Based on observatifailed to ensure 3 or basement storage redoors, and 1 of 1 A not equipped with a outside of the door the case of fire or or accordance with LS practice could affect staff while in the bactivities storage refindings include: Based on observatiful p.m. and 4:00 p.m. the Director of Mait the following was referred.	Requirements - Other Requirements - Other RKS section any LSC 19.2 Means of Egress are not addressed by the out are deficient. This g with the applicable Life FPA standard citation, d on Form CMS-2567. on and interview, the facility f 3 egress doors from the large oom/area, 1 of 47 resident room ctivities storage room, were a latch or lock device on the to ensure full instant use in other emergencies in SC 7.1.10.1. This deficient et one resident in room 2 and asement storage room/area and oom. ons on 09/14/22 between 1:15 during a tour of the facility with intenance and Administrator,	K 0200	The plan of correction constitute the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction submitted to meet requirement established by state and federal law. Attached for your review an approval, is the completed plan correction for the recent Life and Safety Code Survey, Event ID 5IVX21, conducted on Septemb 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our	his I is I id of d per			

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

Event ID:

basement storage room/area that had latches with

locks on the corridor side of the room/area that

could not be opened from inside this area

5IVX21

Facility ID: 000304

allegation of compliance.

Compliance is effective October 3.

2022. Shadynook Care Center

If continuation sheet

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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	JILDING	01	COMPL	ETED
		155525	B. W	ING		09/14/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			LEY DR		
SHADV	NOOK CARE CENT	FR					
SHADIT	NOOK CARE CENT	LIX		LAWRENCEBURG, 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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		rities storage room within the			also respectfully requests a de		
		n had a latch with a lock on			review for this plan of correction	on.	
		oor that could not be opened			K 0200		
	from inside this roo				It is the policy of Shadynook (Care	
	c. Room 2 had a push button lock on the door with the push button side on the corridor side of				Center to ensure that egress		
					doors are equipped with a late	h or	
		ld not be unlocked and opened			lock devise on the door to ens	ure	
	from inside the room.				full instant use in the case of f	ire	
	Based on interview at the time of each				or another emergency.		
		rector of Maintenance agreed			What corrective action will be	е	
		ot be unlocked from the inside			accomplished for those		
	while the latches an	d locks were in place.			residents found to be affecte	d	
					by the deficient practice?		
		viewed with the Director of			No residents or staff were four	nd to	
	Maintenance and A	dministrator during the exit			be affected due to alleged the		
	conference.				deficient practice. Lock was		
					immediately changed on room	(2)	
	3.1-19(b)				door to ensure lock mechanisr	m	
					was on the inside of the door t	0	
					ensure instant use. Three note	ed	
					plywood doors to the basemer	nt	
					storage room/area had doorkr	obs	
					installed with latch/lock		
					mechanism on the inside of th	е	
					door to ensure instant use in e	event	
					of emergency. The C Hall acti	vities	
					storage room within the nurse	s	
					station had lock removed to		
					ensure instant use in the even	t of	
					fire or emergency.		
					How other residents have the	9	
					potential to be affected by th	е	
					same deficient practice will b		
					identified and what correctiv	е	
					action will be taken?		
					All residents or staff have the		
					potential to be affected by the		
					alleged deficient practice. The		
					corrective action for this defici	ent	
			1		practice included removal of		

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Event ID:

5IVX21

Facility ID: 000304

If continuation sheet

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/14/2022
	PROVIDER OR SUPPLIEI		36 VAI	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) latch/lock mechanisms and placed appropriately to comp with state and federal law, ensuring instant-use in the evorage of fire or emergency. All other doors were inspected to ensure compliance. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance will ensure that doors have correct lock/latch mechanisms to maintain instance in the event of fire or emergency. Maintenance or administrator will audit doors weekly X4 weeks then month months. All audits will be reviet at QAPI for continued compliance the deficient practice will not recur? The corrective action will be monitored by the Maintenance Director or Administrator/designee.	pate ly vent r ure nto all ly X 6 ewed ance. on
K 0211 SS=B	NFPA 101 Means of Egress	- General			

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Means of Egress - General

Aisles, passageways, corridors, exit

discharges, exit locations, and accesses are in accordance with Chapter 7, and the means

Bldg. 01

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If continuation sheet

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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 <u>01</u>	(X3) DATE SURVEY COMPLETED 09/14/2022	
	PROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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
	of egress is continall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of the basement/lower maintained free of compactice could affect not go to the basem. Findings include: Based on observation p.m. and 4:00 p.m. the Director of Mainthere were five chain basement/lower level interview at the time the Director of Mainthere for sever. This finding was reconstructed.	uously maintained free of full use in case of s modified by 18/19.2.2 110.1 on and interview, the facility for a corridor means of egress in level was continuously obstructions. This deficient at staff only since residents do ent/lower level. ons on 09/14/22 between 1:15 during a tour of the facility with intenance and Administrator, are stored in the el egress corridor. Based on the of observation, when asked, intenance said the chairs had	K 0211	The plan of correction constitute written allegation of compliance for the deficiencie cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correctis submitted to meet requirement established by state and feder law. Attached for your review approval, is the completed plat correction for the recent Life as Safety Code Survey, Event ID SIVX21, conducted on Septer 14, 2022 at Shadynook Care Center. Please be advised the is our intent to have this plan correction also serve as our allegation of compliance. Compliance is effective Octobe 2022. Shadynook Care Center also respectfully requests a deview for this plan of correction to the recent in the plan of correction to ensure that aisles, passageways, corridors, exit discharges, exit locations and accesses are maintained free all obstructions to full use in of emergency. What corrective action will be accomplished for those residents found to be affected.	on is and and an of and of and of and of are esk on. Care

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/14/2022	
	ROVIDER OR SUPPLIE		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, 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	
				by the deficient practice? No residents, staff or visitors of affected by the alleged deficient practice. All aisles, passagew corridors, exit discharges, exit locations were audited to ensino obstructions were present. Immediately X5 chairs stored lower level/basement area weremoved from area to ensure clearance of obstruction(s). How other residents have the potential to be affected by the same deficient practice will lidentified and what corrective action will be taken? All residents, staff or visitors in the potential to be affected by alleged deficient practice. The corrective action for the deficient practice includes ensuring that aisles, passageways, corridor exit discharges and exit location are clear and free of obstruction immediately removing X5 chat located in corridor of lower level/basement area. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director will complete audit of all aisles, passageways, corridors, exit discharges and exit locations weekly ongoing to ensure compliance and areas are free any obstruction(s).	were ent ays, t ure in ere e ne be ve nave the e ent at all ss, ons on; irs	

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How will the corrective action

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155525	A. BU B. W	JILDING ING	01	09/14	/2022
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD LEY DR		
SHADY I	NOOK CARE CENT	TER		LAWRE	ENCEBURG, IN 47025		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5)
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with requires the use of egress side unles special locking and CLINICAL NEEDS LOCKING Where special loc clinical security no used, only one loc permitted on each be made for the ra by: remote contro locks or keys carr other such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of the the Clinical or Sec are being met. In	ed means of egress shall not a latch or a lock that of a tool or key from the s using one of the following rangements: S OR SECURITY THREAT cking arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants I of locks; keying of all ied by staff at all times; or e means available to the .2.2.6, 19.2.2.2.5.1,		IAU	be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the maintenar director or designee. Any ar concern will be brought to the committee for review.	e nce eas of	DATE
	building is protect	of power to the device; the ed by a supervised er system and the locked					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	01	COMPL	LETED
		155525	B. WING			09/14	/2022
NAME OF T	DROLUDED OF CURRY		STI	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C	36	VALL	LEY DR		
SHADY I	NOOK CARE CENT	ER	LA	LAWRENCEBURG, IN 47025			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCE		DATE
		d by a complete smoke (or is constantly monitored					
	· · · · · · · · · · · · · · · · · · ·	ation within the locked					
		the sprinkler and detection					
		iged to unlock the doors					
	upon activation.	iged to difficer the doors					
	18.2.2.2.5.2, 19.2	.2.2.5.2. TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT						
		lelayed-egress locking					
		in accordance with					
	_	permitted on door					
		g low and ordinary hazard					
	contents in buildings protected throughout by an approved, supervised automatic fire						
	detection system	or an approved, supervised					
	automatic sprinkle	er system.					
	18.2.2.2.4, 19.2.2	.2.4					
	ACCESS-CONTR	OLLED EGRESS					
	LOCKING ARRAN	NGEMENTS					
	Access-Controlled	d Egress Door assemblies					
	installed in accord	lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2						
		BY EXIT ACCESS					
	LOCKING ARRAN						
	1	t access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
	1	ised automatic sprinkler					
	system.	0.4					
	18.2.2.2.4, 19.2.2		17.0000		The plan of an C C	.4	10/14/2022
		on and interview, the facility	K 0222		The plan of correction constitu	ites	10/14/2022
		f 3 delayed egress locking			the written allegation of	_	
		installed in accordance with			compliance for the deficiencies		
	` ′	hich states an irreversible			cited. However, submission of	เทเร	
	_	e the lock in the direction of conds, or 30 seconds where			plan of correction is not an admission that the deficiency		
	i cricos minimi i.) sec	conds. Of 30 seconds where	1		aumission mai me deliciency		i .

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525		JILDING	ONSTRUCTION 01	(X3) DATE COMPI 09/14	LETED
NAME OF I	PROVIDER OR SUPPLIER	· ?	_		ADDRESS, CITY, STATE, ZIP COD		
SHADY I	NOOK CARE CENT	TER .			LEY DR ENCEBURG, IN 47025		
(X4) ID	T	STATEMENT OF DEFICIENCIE		ID	<u> </u>		(V5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	 	thority having jurisdiction,		1710	exists or that one was cited		DITTE
		a force to the release device			correctly. This plan of correcti	on is	
	required in 7.2.1.5.10 under all of the following				submitted to meet requiremen		
	conditions:	- · · · · · · · · · · · · · · · · · · ·			established by state and fede		
	(a) The force shall not be required to exceed 15 lbf (67 N).				law. Attached for your review		
					approval, is the completed pla		
	` '	not be required to be			correction for the recent Life a		
		ed for more than 3 seconds.			Safety Code Survey, Event ID		
	(c) The initiation of the release process shall activate an audible signal in the vicinity of the				5IVX21, conducted on Septer		
					14, 2022 at Shadynook Care		
	door opening.				Center. Please be advised that	at it	
	(d) Once the lock h	as been released by the			is our intent to have this plan	of	
	application of force	to the releasing device,			correction also serve as our		
	relocking shall be b	y manual means only. This			allegation of compliance.		
	deficient practice could affect up to 60 residents,				Compliance is effective Octob	er 3.	
	as well as staff and visitors.				2022. Shadynook Care Cente	r	
					also respectfully requests a d	esk	
	Findings include:				review for this plan of correcti	on.	
	Based on observation	ons on 09/14/22 between 1:15			K 0222		
	p.m. and 4:00 p.m.	during a tour of the facility with			It is the policy of Shadynook (Care	
	the Director of Mai	ntenance and Administrator, all			Center to ensure that delayed		
	three exit doors equ	sipped with a 15 second		egress locking arrangements are			
		e tested to ensure the			installed in accordance with s	tate	
	_	to release the magnetic lock			and federal law.		
		vorking properly. These doors					
		he Supervisory Station			What corrective action will be		
		C halls, the Dining Room, and			accomplished for those reside	ents	
		The panic bars on these			found to be affected by the		
	•	for over 3 seconds each and			deficient practice?		
		alarm did activate for each			No residents or staff were affe		
		hen the panic bar was			by the alleged deficient practic	ce. A	
		s did not release from the			work order with Safecare is	الم	
	_	er 15 seconds. When the panic			created to ensure the identifie	a	
	bars were pushed for over 15 seconds straight the doors did release from the magnetic locks and				doors: the door near the	and	
					supervisory station between [
		ened, furthermore, the doors did agnetic lock when the code on			C halls, the dining room door the "B" hall exit door are all	ailu	
		ssed. Based on interview at			equipped with a delay of 15		
		servation, the Director of			seconds, as well as having ar		
	I are time of each ob	ber radion, the Director of	1		I soconius, as well as naving al	ı	I

5IVX21

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE			ETED	
		155525	B. W	ING		09/14/	/2022
				CTDEET /	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LEY DR		
CHADYA	JOOK CARE CENT	·FD					
SHADY	NOOK CARE CENT	ER		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 APPROPRIATE		TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Maintenance agreed	l the previously mentioned			irreversible process. Ensuring	the	
	exit doors were not	operating as designed and			doors function properly and ar	e in	
	need to ensure the in	rreversible process to release			compliance with state and fed	eral	
	the magnetic lock of	n each door works properly.			law.	•	
					Dictation reviewed on the 256	7	
	This finding was re-	viewed with the Director of			and noted on page 13 of 47		
	Maintenance and A	dministrator during the exit			states, "the identified doors did	b	
	conference.				release from the magnetic locl	ks	
					when the door code on the ke	ypad	
	3.1-19(b)				was pressed."		
					How other residents have the		
					potential to be affected by the		
					same deficient practice will be		
					identified and what corrective		
					action will be taken?		
					All residents and/or staff have	the	
					potential to be affected by the		
					alleged deficient practice. A w	ork	
					order with Safecare is initiated	l for	
					the (3) identified doors to ensu	ıre	
					all mechanisms are functioning	g	
					properly, that the identified do	ors	
					are equipped with a delay of 1	5	
					seconds, as well as having an		
					irreversible process. All other		
					doors in facility were audited t	0	
					ensure proper locking		
					mechanisms were correct;		
					meeting compliance in		
					accordance with state and fed	eral	
					law.		
					What measures will be put into)	
					place and what systemic chan	ges	
					will be made to ensure that the	Э	
					deficient practice does not rec	ur?	
					The maintenance director or		
			1		designee will audit all exit doo	rs	

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Event ID:

5IVX21

Facility ID: 000304

weekly for compliance.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155525	B. W	ING		09/14/	2022
	PROVIDER OR SUPPLIE			36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR 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 APPROPRIA	\TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					All negative findings will be immediately remedied and administrator will be notified. Findings will be brought to the safety committee meeting and monthly to QAPI. Administrate monitor. How will the corrective action monitored to ensure the defici practice will not recur? The corrective action will be completed by the maintenance director or designee. The administrator will monitor corrective actions.	d or to be dent	
K 0281 SS=E Bldg. 01	discharge, is arra and shall be either or capable of automanual intervention 18.2.8, 19.2.8 Based on observation failed to ensure 1 on properly lighted and darkness. LSC 7.8 be arranged so that lighting unit does relevel of less than 0 designated area. The affect up to 61 residuals and shall be arranged so that lighting unit does relevel of less than 0 designated area. The affect up to 61 residuals are and the arranged so that lighting unit does relevel of less than 0 designated area. The affect up to 61 residuals are are arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area. The arranged so that lighting unit does relevel of less than 0 designated area.	eans of Egress eans of egress, including exit nged in accordance with 7.8 er continuously in operation omatic operation without	K 0	281	The plan of correction constituthe written allegation of compliance for the deficiencie cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correctis submitted to meet requirement established by state and feder law. Attached for your review approval, is the completed plat.	on is tral	10/03/2022

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Findings include:

Event ID:

5IVX21

Facility ID: 000304

)4

correction for the recent Life and Safety Code Survey, Event ID

If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER 155525	A. BUILDING B. WING	01	COMPLETED 09/14/2022
	ROVIDER OR SUPPLIER		36 VAL	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 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
	p.m. and 4:00 p.m. of the Director of Main the dining room coulighting directly out porch overhang, how provided beyond the sidewalk that lead to located around a continuous at the time of Maintenance agreexterior light provided.	ons on 09/14/22 between 1:15 during a tour of the facility with intenance and Administrator, intyard exit was provided with side the exit door under the wever, there was no lighting the porch overhang for the to the exit gate which was rier of the building. Based on the of observation, the Director the differenced to be more the differenced within the courtyard. In wiewed with the Director of the diministrator during the exit		5IVX21, conducted on Septem 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective Octob 2022. Shadynook Care Center also respectfully requests a dereview for this plan of correction E 0281 It is the policy of Shadynook Center that adequate illumination be provided to ensure enough is provided for path of exit; emergency exits, in event of emergency. What corrective action will be accomplished for those residents found to be affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. After further review, a work or has been created to ensure installment of two flood lights allowing complete illumination clear pathway in courtyard and described areas. Flood lights allowing complete illumination clear pathway in courtyard and described areas. Flood lights be directly tied to emergency generator to ensure continued illumination following exit through the same deficient practice will be identified and what corrective action will be taken?	er 3. r esk on. Care tion light e e d ected be. der and d will lugh

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIP A. BUILDIN B. WING	DLE CONSTRUCTION NG 01	(X3) DATE SU COMPLE ² 09/14/2	ΓED
	ROVIDER OR SUPPLIER		36	REET ADDRESS, CITY, STATE, ZIP COD VALLEY DR WRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APPRO	ION D BE DPRIATE	(X5) COMPLETION DATE
				All residents and/or staff h potential to be affected by alleged deficient practice. flood lights wired to emerging generator to be installed to courtyard to ensure complibility of an emergency. What measures will be purplace and what systemic of will be made to ensure that deficient practice does not be resurring continued illuminant clear exit pathway three courtyard exit. How will the corrective act monitored to ensure the depractice will not recur? This correction action and completion will be overseed administrator or maintenar director or designee. =""" p="">	the Two ency ency ete way exit t into changes t the recur? tied to em ation ough ion be eficient	
K 0293 SS=E Bldg. 01	accordance with 7	al signs are displayed in .10 with continuous erved by the emergency				

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155525	B. W	ING		09/14/	/2022
		<u> </u>	-1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			LEY DR		
SHADY N	NOOK CARE CENT	ER			ENCEBURG, IN 47025		
					1		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	19.2.10.1						
	(Indicate N/A in or	-					
	· ·	less than 30 occupants					
		exit travel is obvious.)	17.0	202	The plan of correction constitution	ıtaa	10/02/2022
		on and interview, the facility astall exit signage within 1 of 1	K 0	293	The plan of correction constitu	ues	10/03/2022
		ance with LSC 7.10. LSC			the written allegation of	6	
	*	her than main exterior exit doors			compliance for the deficiencie cited. However, submission of		
		clearly are identifiable as exits,			plan of correction is not an	นแอ	
		an approved sign that is			admission that the deficiency		
		any direction of exit access.			exists or that one was cited		
	LSC 7.10.1.2.2 states horizontal components of the				correctly. This plan of correction	on is	
	egress path within an exit enclosure shall be				submitted to meet requirement		
	marked by approved exit or directional exit signs				established by state and feder		
		ion of the egress path is not			law. Attached for your review		
		eient practice could affect up to			approval, is the completed pla		
		l as staff and visitors in the			correction for the recent Life a		
		ling to exit through the			Safety Code Survey, Event ID		
	courtyard.	- -			5IVX21, conducted on Septen		
					14, 2022 at Shadynook Care		
	Findings include:				Center. Please be advised that	at it	
					is our intent to have this plan	of	
		ons on 09/14/22 between 1:15			correction also serve as our		
		during a tour of the facility with			allegation of compliance.		
		ntenance and Administrator,			Compliance is effective Octob		
		k leading to the courtyard			2022. Shadynook Care Cente		
		e was no directional exit sign			also respectfully requests a de		
	•	uld lead residents and staff to			review for this plan of correction	on.	
	_	ne courtyard porch. The exit			K 0293	_	
	-	ound the corner of the building			It is the policy of Shadynook		
		en from the courtyard porch.			Center to ensure exit signage		
		at the time of observation, the			properly installed for clarity of		
		nance agreed there was no			pathway in the event of an		
	_	in the courtyard to lead			emergency.	_	
	residents and staff t	o me exit gate.			What corrective action will b	е	
	This finding was ==	viewed with the Director of			accomplished for those	d	
	_				residents found to be affecte	eu	
	conference.	dministrator during the exit			by the deficient practice? No residents or staff were affer	octod	
	conference.						
			1		by the alleged deficient practic	Je.	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED
		155525	B. WI	NG		09/14/2022
		.		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R		36 VAL	LEY DR	
SHADY I	NOOK CARE CENT	ΓER		LAWRE	ENCEBURG, IN 47025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	3.1-19(b)				Please see attached emergen	-
					exit plan. Emergency illuminat	I
					exit signage was installed on good directly in front of exit door to	jale
					ensure clear pathway to	
					emergency exit gate located in	n the
					courtyard.	
					How other residents have the	e
					potential to be affected by th	e
					same deficient practice will b	oe e
					identified and what correctiv	e
					action will be taken?	
					All residents, staff and visitors	
					have the potential to be affect	I
					by the alleged deficient practic	I
					Emergency exit signage has b	I
					installed properly to facility's g	I
					directly in front of emergency	
					door to ensure clear designate pathway in the event of an	;u
					emergency.	
					What measures will be put in	uto
					place and what systemic	
					changes will be made to	
					ensure that the deficient	
					practice does not recur?	
					The maintenance director did	
					complete audit of all emergen	•
					exits to ensure clarity of pathw	/ay
					is known in the event of an	
					emergency. The maintenance	I
					director and administrator ens	
					proper installment of illuminate	ea
					exit signage on gate located	ovit
					directly in front of emergency door according to facility's	EXIL
					emergency exit plan.	
					How will the corrective action	n
					be monitored to ensure the	·· [
					deficient practice will not	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2022		
	PROVIDER OR SUPPLIEF			36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, 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 APPROPRIAT DEFICIENCY) recur?	ΓE	(X5) COMPLETION DATE
					The corrective action will be completed and overseen by the Maintenance director or design to ensure illuminated exit signaremains properly installed to facility's gate. Any areas of concern will be brought to the committee for review.	nee age	
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automatoption is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated to by smoke resisting terrors in accordance with 8.4.					
	a. Boiler and Fuel b. Laundries (larg c. Repair, Mainter	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64					

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gallons)

e. Trash Collection Rooms

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155525	B. W	NG		09/14/2022	
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD LEY DR		
CHADYA	JOOK CARE CENT	TD.					
SHADY	NOOK CARE CENT	ER		LAWRE	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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(exceeding 64 gal	lons)					
	f. Combustible Sto	orage Rooms/Spaces					
	(over 50 square fe	•					
		classified as Severe					
	Hazard - see K32	,					
		ation and interview, the	K 0	321	The plan of correction constitu	ıtes	10/03/2022
	1	sure 1 of 1 egress corridor in			the written allegation of		
		level was not used to store			compliance for the deficiencies		
		al. This deficient practice			cited. However, submission of	this	
	could affect mostly				plan of correction is not an		
		el, plus up to 20 residents from			admission that the deficiency		
	the C hall.				exists or that one was cited		
	Findings include:				correctly. This plan of correction		
					submitted to meet requiremen		
		00/14/001			established by state and feder		
		ons on 09/14/22 between 1:15			law. Attached for your review		
	1	during a tour of the facility with			approval, is the completed pla		
		ntenance and Administrator,			correction for the recent Life a		
	the following was n				Safety Code Survey, Event ID		
		e area in basement was full of			5IVX21, conducted on Septem	nber	
	_	aper, plastic, old furniture,			14, 2022 at Shadynook Care	.4 :4	
		nd a variety of other storage area was open to the corridor			Center. Please be advised that		
	_	separates the storage area			is our intent to have this plan of	וכ	
		ridor only extending up about			correction also serve as our		
		oor to the top of the wall. The			allegation of compliance. Compliance is effective Octob	or 3	
		to the ceiling, but was open			2022. Shadynook Care Cente		
		the ceiling across the entire			also respectfully requests a de		
	storage area.	and defining decrees the entire			review for this plan of correction		
	_	east 50 cardboard boxes full of			K 0321		
		ared on wood pallets in the area			It is the policy of Shadynook (Care	
		at/lower level exit door.			Center to ensure that the egre		
		rea would have to be traversed			corridor is in compliance with		
		ff from the C hall to exit in the			code and has an automatic fire		
	1 -	ency and unable to exit to the			extinguishing system in place.		
	northeast end of the C hall.				What corrective action will b		
	c. There was combustible storage and cleaning				accomplished for those	-	
	equipment stored at the northeast end of the				residents found to be affecte	d	
		el within a small room only			by the deficient practice?	-	
		corridor by two metal grated			No residents, staff or visitors v	vere	
1					•		

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155525	B. W	ING		09/14/2	2022
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	2			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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	doors. These metal grated doors would not				affected by the alleged deficie		
	protect the egress corridor in the event of smoke				practice. A work order has bee	en	
	or fire from this room.				created to install a wired smok	ке	
		at the time of observations,			detector by the housekeeping		
	the Director of Maintenance said the previously				cage in the lower level/baseme	ent.	
	mentioned items have been this way ever since				Two wired smoke detectors to	be	
	he's been at the facility.				installed in the lower		
					level/basement. One wired sm	I	
	This finding was reviewed with the Director of				detector will replace a wired he		
		dministrator during the exit			detector in place. Work order t		
	conference.				be completed by 10 days. Do	or	
					closures added to maintenanc	I	
	3.1-19(b)				shop door and activity room do	oor.	
					All combustibles will be remov	ed	
		ration and interview, the			from the area next to the		
	_	sure the corridor doors to 2 of			basement level exit door.		
		area doors, such as an activity			How other residents have the	I	
		and maintenance room door,			potential to be affected by th	e	
	_	self closing devices. This			same deficient practice will b	oe	
	-	ould affect at least 50 residents,			identified and what correctiv	e	
		thile in the dining room which			action will be taken?		
		oke compartment as the			All residents, staff or visitors h		
	Activity Room.				the potential to be affected by		
					alleged deficient practice. The		
	Findings include:				corrective action includes ensu	uring	
					there is an automatic fire		
		ons on 09/14/22 between 1:15			extinguishing system in place	by	
		during a tour of the facility with			installing x3 wired smoke		
		ntenance and Administrator,			detectors, door closures adde	d to	
	the following was n				maintenance shop door and		
		om was over 50 square feet in			activity room door and all		
		nbustible items such as			combustibles removed from th		
		aper, and plastic items plus			area next to the basement leve	el	
		torage items. The corridor			exit door.		
		as not provided with a self			What measures will be put in	ito	
	_	sure the door would close			place and what systemic		
	automatically.				changes will be made to		
		e Room in the basement/lower			ensure that the deficient		
		quare feet in size, and full of			practice does not recur?		
	combustible items s	such as cardboard boxes and			The maintenance director to		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/14/2022
	PROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	corridor door to this self closing device to automatically. Based on interview observation, the Dirthe doors to these two not self close automatical to the self close automatical the self close automatical to the se	nent and supplies. The aroom was not provided with a so ensure the door would close at the time of each ector of Maintenance agreed to hazardous area rooms diduatically when tested. Viewed with the Director of doministrator during the exit		ensure basement/lower lever continues to meet requirem for an automatic fire extinguity system in the corridors. Are separated from the other special by smoke resisting partition. Ensure that all needed door door closures as required by and federal law and all combustibles away from egareas. How will the corrective active active monitored to ensure the deficient practice will not recur? The corrective actions and automatic fire extinguishing system will be monitored by maintenance director or des All negative findings will be remedied immediately and administrator to be notified. Results will be brought to the monthly QAP meeting. Administrator to monitor.	ents uishing as are paces s. rs have y state ress tion e
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/14/2022		
		ROVIDER OR SUPPLIEF			36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
		* cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2 enclosed as haza be open to the cooking facilities through 19.3.2.5.5 Based on observation failed to ensure the Therapy room was in use. LSC 19.3.2 compartment, reside equipment that is us fewer persons shall the cooking facility conditions: (1) The space contains is not a sleeping rook (2) The space contains and (13) are met. 19.3.2.5.3(9) states following is provided (a) A locked switch restricted location, facility that deactive (b) The switch is us or range whenever supervision. This deficient practice.	sin smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 on and interview, the facility cook tops in 1 of 1 Physical shut off at the switch when not .5.4 states within a smoke ential or commercial cooking sed to prepare meals for 30 or be permitted, provided that complies with all the following sining the cooking equipment from the corridor by partitions 3.6.2 through 19.3.6.5. ts of 19.3.2.5.3(1) through (10)	K 0	324	The plan of correction constitute written allegation of compliance for the deficiencie cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correctic submitted to meet requirement established by state and feder law. Attached for your review approval, is the completed plat correction for the recent Life as afety Code Survey, Event ID 5IVX21, conducted on Septen 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective Octob 2022. Shadynook Care Center also respectfully requests a dereview for this plan of correction K0324. It is the policy of Shadynook Center to ensure cook tops ar shut off at the switch when no use.	s this on is tral and n of nd hber at it of esk on.	10/03/2022

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLE	TED
		155525	B. W	TNG		09/14/2	022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L.			LEY DR		
SHADY N	NOOK CARE CENT	ER			ENCEBURG, IN 47025		
(X4) ID		STATEMENT OF DEFICIENCIE	ı	ID	Ī	Т	(Y5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		ons on 09/14/22 between 1:15		IAG	What corrective action will b	_	DATE
		during a tour of the facility with			accomplished for those		
		ntenance and Administrator,			residents found to be affected	,d	
		stove in the Physical			by the deficient practice?	,	
	-	e oven portion was full of			No residents, staff or visitors v	were	
		ling a tool box, plus paper and			affected by the alleged deficie		
		op of the stove had paper			practice. The wire plug in		
	-	rs. When asking about the			mechanism for the stove to		
	-	urned off when not in use,			operate was immediately rem	oved	
	Physical Therapy st	aff person #1 said the			and a plate was added to cove		
	stove/oven was a m	ock stove that did not have			any ability to utilize the operat	ing	
	power, it was only t	used for training purposes.			plug. A face plate was added	over	
	When the front righ	t burner was turned on, it did			the outlet ensuring the stove of	could	
	turn red and produc	e heat.			not be functional in any capac	ity.	
					How other residents have the	е	
	-	viewed with the Director of			potential to be affected by the	ie	
	Maintenance and A	dministrator during the exit			same deficient practice will be	ре	
	conference.				identified and what correctiv	re	
					action will be taken?		
	3.1-19(b)				All residents, staff or visitors h		
					the potential to be affected by		
					alleged deficient practice. The		
					corrective action for this defici		
					practice included full removal		
					the plug, plate added covering		
					back of the stove and face pla		
					covering applicable outlet add		
					What measures will be put in	ווט	
					place and what systemic		
					changes will be made to ensure that the deficient		
					practice does not recur?		
					The maintenance		
					director/designee will ensure t	that	
					the stove located in the therap		
					gym remains fully non-operati	- 1	
					How will the corrective actio		
					be monitored to ensure the		
					deficient practice will not		
					recur?		

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Event ID:

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/14/2022
	PROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 corrective action will be monitored by the maintenance supervisor or designee. Any a of concern will be brought to t QA committee for review.	reas
K 0331 SS=E Bldg. 01	exposed interior s as fixed or movab columns, and have Class A or Class E	ceiling Finish eiling finishes, including urfaces of buildings such le walls, partitions, e a flame spread rating of 3. The reduction in class of sprinkler system as 8.1 is permitted. 3.3.2			
	failed to ensure 1 of basement/lower leve Class A or Class B 10.2.3.4 states prod accordance with AS Method for Surface Building Materials, Test for Surface Bu Building Materials, accordance with the smoke developed in 10.2.3.4(4):	on and interview, the facility I egress corridor in the el had a flame spread rating of for a sprinklered facility. LSC acts required to be tested in ITM E 84, Standard Test Burning Characteristics of or ANSI/UL 723, Standard for rning Characteristics of shall be classified as follows in ir flame spread index and dex, except as indicated in wall and ceiling finish shall be	K 0331	The plan of correction constitute written allegation of compliance for the deficiencie cited. However, submission or plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correcti submitted to meet requirement established by state and fede law. Attached for your review approval, is the completed plat correction for the recent Life a Safety Code Survey. Event ID	on is on is ral and an of and

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525		JILDING	INSTRUCTION 01	(X3) DATE S COMPL 09/14/	ETED
	PROVIDER OR SUPPLIER		•	36 VALI	ADDRESS, CITY, STATE, ZIP COD LEY DR NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	NTE	(X5) COMPLETION DATE
TAG	characterized by the (a) Flame spread ine (b) Smoke develope (2) Class B interior characterized by the (a) Flame spread ine (b) Smoke develope (3) Class C interior characterized by the (a) Flame spread ine (b) Smoke develope (4) Existing interior smoke developed ine (b), and (3)(b). This deficite only since residents basement/lower lev Findings include: Based on observation p.m. and 4:00 p.m. the Director of Main the corridor wall be level large storage r only about six feet the wall, furthermore, the within the length of of painted plywood Based on interview Director of Mainter did not have a propo- he knew. This finding was re-	e following: dex, 0-25 ed index, 0-450 wall and ceiling finish shall be e following: dex, 26-75 ed index, 0-450 wall and ceiling finish shall be e following: dex, 76-200 ed index, 0-450 efinish shall be exempt from the dex criteria of 10.2.3.4(1)(b), (2) ent practice could affect staff don't go to the		TAG	5IVX21, conducted on Septer 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan correction also serve as our allegation of compliance. Compliance is effective Octobe 2022. Shadynook Care Center also respectfully requests a direview for this plan of correction K 0331. It is the policy of Shadynook Center to ensure that interior and ceiling finishes, including exposed interior surfaces of the facility have a flame spread rate of Class A or Class B. What corrective action will be accomplished for those residents found to be affected by the deficient practice? No residents, staff or visitors of affected by the alleged deficient practice. The corridor wall be the basement/lower-level larg storage room and egress corrective that is described as painted plywood, has been replaced of the surface that has a flame spread rating of class A or class B per regulation. Smoke detectors to added to the area to ensure a wired supervised smoke detectors to added to the area to ensure a wired supervised smoke detectors to a supervised smoke detector	nber at it of er 3. r esk on. Care wall ne ting e d were ent ween e idor vith a ad r o be ction e ne e	DATE
					, rooidorito, otdii oi violtoi oi		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			LETED	
		155525	B. W	ING		09/14	/2022
					_		-
NAME OF P	PROVIDER OR SUPPLIEI	8			ADDRESS, CITY, STATE, ZIP COD		
	no viden on borrein.			36 VAL	LEY DR		
SHADY N	NOOK CARE CENT	ΓER		LAWRE	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		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the potential to be affected by	the	
					alleged deficient practice. A		
					facility wide audit of smoke		
					detectors was completed with	all	
					other areas noted to be in		
					compliance. Wall surfaces tha	t did	
					not meet the class A or B ratin		
					have been replaced. Smoke		
					detectors to be added to the n	oted	
					area of non-compliance to ens		
					a supervised smoke detection		
					system is in place.		
					What measures will be put in	ito	
					place and what systemic	110	
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					The administrator or maintena		
					director/designee shall ensure	ınaı	
					ensure that a wired smoke		
					detector system is in place to		
					meet compliance. Maintenance		
					director was educated in refer		
					to the requirement of a superv		
					smoke detector system as we		
					the flame spread rating for wa	II	
					coverings.		
					How will the corrective action	n	
					be monitored to ensure the		
					deficient practice will not		
					recur?		
					The corrective actions will be		
					completed by the administrato		
					maintenance director or design	nee.	
					Any areas of concern will be		
					brought to the QA committee t	or	
					review.		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			01	COMPLETED	
		155525	B. WING 09			09/14/	/2022
		<u> </u>		STREET A	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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX					(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION				DEFICIENCY)		DATE
K 0341	NFPA 101						
SS=F	Fire Alarm System - Installation						
Bldg. 01	Fire Alarm System - Installation						
	A fire alarm system is installed with systems						
	and components approved for the purpose in						
	accordance with NFPA 70, National Electric						
	Code, and NFPA 72, National Fire Alarm						
	Code to provide effective warning of fire in any						
	part of the building. In areas not continuously						
	occupied, detection is installed at each fire						
	alarm control unit. In new occupancy,						
	detection is also installed at notification						
	appliance circuit power extenders, and						
	supervising station transmitting equipment.						
	Fire alarm system wiring or other						
	transmission paths are monitored for						
	integrity.						
	18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8		TT 00.41		The along of comment (2011)		10/02/2022
	Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control		K 0341		The plan of correction constitu	itutes 10/03/2022	
					the written allegation of	_	
_		was protected. NFPA 72,			compliance for the deficiencies		
		and Signaling Code Section sthat are not continuously			cited. However, submission of	เกเร	
					plan of correction is not an		
_		e smoke detection shall be tion of each fire alarm control appliance circuit power			admission that the deficiency exists or that one was cited	d	
-							
		rvising station transmitting			correctly. This plan of correction submitted to meet requiremen		
	equipment to provide notification of fire at that				· '		
	location.				established by state and federal law. Attached for your review and		
		mbient conditions prohibit			approval, is the completed pla		
	installation of automatic smoke detection,				correction for the recent Life and		
		ction shall be permitted.			Safety Code Survey, Event ID		
		arm control unit(s) that are to be			5IVX21, conducted on Septem		
	protected are those that provide notification of a				14, 2022 at Shadynook Care		
	_	s and responders. The term			Center. Please be advised tha	t it	
	•	nit does not include equipment			is our intent to have this plan of		
		s and addressable devices.			correction also serve as our		
		etection at the transmitting			allegation of compliance.		
		equipment is intended to increase the probability			Compliance is effective Octob	er 3.	
		will be transmitted to a			2022 Shadynook Care Center		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) D			RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLET	ED
		155525	B. W	ING		09/14/20	122
				CED DEET	ADDRESS STEV STATE STR SOD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
SHVDA I	NOOK CARE CEN	TED			LEY DR ENCEBURG, IN 47025		
SHADTI	NOOK CARE CEN	IER		LAWKE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	supervising station	prior to that transmitting			also respectfully requests a de	esk	
	equipment being d	isabled due to the fire			review for this plan of correction	on.	
	condition.				K 0341		
	CAUTION: The ex	acception to 10.15 permits the use			It is the policy of Shadynook	Care	
	of a heat detector is	f ambient conditions are not			Center to ensure that the fire		
	suitable for smoke	detection. It is important to			alarm control annunciator pan	els	
		her the area is suitable for the			are protected.		
		re the area or room containing			What corrective action will b	е	
	the control unit is p				accomplished for those		
		overage, additional smoke			residents found to be affecte	ed	
	detection is not req	uired to protect the control			by the deficient practice?		
	unit. Where				No residents, staff or visitors v	vere	
	total smoke-detection coverage is not provided,				affected by the alleged deficie	nt	
	the Code intends that only one smoke detector is				practice. A work order is		
	_	trol unit even when the area of			submitted to install a smoke		
		quire more than one detector if			detector by the supervisor des	sk by	
		to the spacing rules in Chapter			one of two annunciator panels	i.	
		elective coverage is to address			How other residents have the	е	
	_	n of the equipment. Location			potential to be affected by th	е	
	_	ection should be in accordance			same deficient practice will be	oe e	
	with one of the foll	_			identified and what correctiv	е	
		ng is 15 feet in height or less,			action will be taken?		
		should be located on the			All residents, staff or visitors h	I	
	_	within 21 feet of the centerline			the potential to be affected by		
		ontrol unit being protected by			alleged deficient practice. The	I	
		ordance with 17.7.3.2.1.			corrective action for this defici		
		ng exceeds 15 feet in height, the			practice includes installation o		
		etector should be installed on			wired smoke detector by the fi	re	
		within 6 feet from the top of			alarm annunciator panel.		
	the control unit.				What measures will be put in	ito	
	This deficient prac	tice could affect all occupants.			place and what systemic		
					changes will be made to		
	Findings include:				ensure that the deficient		
					practice does not recur?		
		ons on 09/14/22 between 1:15			The maintenance director or		
		during a tour of the facility with			designee shall ensure that fire	•	
		intenance and Administrator,			alarm annunciator panels are		
		wired smoke detector located in			protected.		
		fire alarm annunciator panel			How will the corrective actio	n	
	was located on the	wall across from the			be monitored to ensure the		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2022	
	PROVIDER OR SUPPLIER			36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	.TE	(X5) COMPLETION DATE
	time of observation Supervisory Station 24/7. She said staff Supervisory Station Station. The Super at the time of obser This finding was re	Based on an interview at the the Administrator said the was not always occupied would switch between the and the C hall Nurses' visory Station was unoccupied wation with the lights out.			deficient practice will not recur? The corrective actions will be completed by the maintenance director or designee. All negatifindings will be immediately remedied and Administrator to notified. Findings will be brout to the safety committee meetin and monthly QAPI. Administration to monitor.	b be ght ng	
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are respected in the National Fire Alarm Records of system and testing are respected in the National Fire Alarm Records of system and testing are respected in the National Record facility failed to ensure the National Records of the N	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0.	345	The plan of correction constituthe written allegation of compliance for the deficiencie cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correctis submitted to meet requirement established by state and feder	on is	10/03/2022
	range, the length of	time between calibration tests to be extended to a maximum of			law. Attached for your review approval, is the completed pla	and	

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5 years. If the frequency is extended, records of

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correction for the recent Life and

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155525		l í	JILDING	onstruction 01	(X3) DATE COMPL 09/14 /	ETED	
	PROVIDER OR SUPPLIER			36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, 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)	TE	(X5) COMPLETION DATE
TAG	detector caused nuit trends of these alarn zones or areas wher increase over the preshall be performed. detector is within it range, it shall be test (1) Calibrated test restaurant. (2) Manufacturer's distribution in transperse (4) Smoke detector arrangement where at the control unit with its listed sensitivity (5) Other calibrated to the authority have Detectors found to listed and marked seleaned and recalibrated and marked seleaned and recalibrated to the detector sensition measured using any an unmeasured condetector. This deficit residents, staff, and Findings include: Based on record revalum. A smoke detector sensition of the call the work "Smoke" as a larm point for each the work "Smoke" as straight line through each page. Based or record review, the I	quipment arranged for the fire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be rated, or replaced. vity cannot be tested or repray device that administers centration of aerosol into the cient practice could affect all visitors. View on 09/14/22 between 10:00 with the Director of dministrator present, the sitivity test report dated complete report. There was no a smoke detector tested, only at the top of the column with a a the rest of the column for on interview at the time of Director of Maintenance		TAG	Safety Code Survey, Event ID 5IVX21, conducted on Septem 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective Octob 2022. Shadynook Care Center also respectfully requests a dereview for this plan of correction K 0345. It is the policy of Shadynook Center to ensure that smoke sensitivity test reports are completed accurately. What corrective action will be accomplished for those residents found to be affected by the deficient practice? No residents, staff or visitors was affected by the alleged deficie practice. The electronic sensitive report was obtained in referent the dated report 2/23/21 indicated a complete report with no line drawn. (See attachment for reference) Electronic report do show documentation availables show the alarm point for each smoke detector tested for sensitivity. The most recent for quarterly fire alarm system inspection/testing reports dated 1/1/17/21 did not match reports dated 5/6/22 and 8/9/22 with a discrepancy of 13 smoke detectors (clarification facility 149 not 50 smoke detectors)	nber at it of er 3. r esk on. Care e d vere nt ivity ce to ating bes e to ur d s a	DATE
	confirmed there wa	s no documentation available	1		unsupervised. A vendor inspe	cuon	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155525	B. WING		09/14/2022
NAME OF I	PROVIDER OR SUPPLIER	,	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	KOVIDEK OK SUI I EIEF		36 VAI	LLEY DR	
SHADY I	NOOK CARE CENT	ER	LAWR	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	to show the alarm p	oint for each smoke detector		was immediately completed w	<i>i</i> ith
	tested for sensitivity	y during the 02/25/21 testing		complete walk through of facil	ity,
	date.			all smoke detectors to be	
				overseen and supervised to m	neet
	This finding was re	viewed with the Director of		compliance of state and feder	al
	Maintenance and A	dministrator during the exit		law.	
	conference.			How other residents have th	e
				potential to be affected by th	ie l
	3.1-19(b)			same deficient practice will I	
	. ,			identified and what corrective	
	2. Based on record	review and interview, the		action will be taken?	
		sure the documentation for the		All residents, staff or visitors h	ıave
	_	devices connected the fire		the potential to be affected by	
	_	omplete and accurate. NFPA		alleged deficient practice. The	
	-	larm Code, the 2010 Edition, at		corrective action for the deficie	
		record of all inspections,		practice includes accurate	
	_	nance shall be provided that		sensitivity electronic report fro	um
	-	ing information regarding tests		previous vendor. Ensuring fac	
		le information requested in		inspection was immediately	,
	Figure 14.6.2.4:	4		completed and all smoke	
	(1) Date			detectors are supervised.	
	(2) Test frequency			What measures will be put in	nto
	(3) Name of proper	tv		place and what systemic	
	(4) Address	-5		changes will be made to	
	* /	performing inspection,		ensure that the deficient	
		or combination thereof, and		practice does not recur?	
		address, and telephone		The maintenance director or	
	number	address, and terephone		designee shall ensure that it is	
		and representative of		complete and accurate, and a	I
	approving agency (•	"
		he detector(s) tested		facility smoke detectors are	
	(8) Functional test	* *		supervised. How will the corrective actio	_
	` '				"
		of required sequence of		be monitored to ensure the	
	operations			deficient practice will not	
	(10) Check of all sn			recur?	
	` ′ *	e for all fixed-temperature,		The corrective actions will be	
	line-type heat detec			completed by the maintenanc	
1	(12) Functional test	of mass notification system		director or designee. All negation	ve I

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control units

(13) Functional test of signal transmission to mass

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findings will be immediately

remedied and Administrator to be

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155525	B. WI	NG		09/14	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		36 VAL	LEY DR		
SHADY	NOOK CARE CENT	TER		LAWRE	ENCEBURG, IN 47025		
(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		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	notification systems				notified. Findings will be brou	-	
		t of ability of mass notification			to the safety committee meetir	ng	
	-	re alarm notification appliances			and monthly QAPI.		
		gibility of mass notification					
	system speakers						
		required by the equipment					
	manufacturer's pub						
		required by the authority					
	having jurisdiction						
	· · · -	ester and approved authority					
	representative						
	` ' *	problems identified during test					
	(e.g., system owner	-					
	corrected/successfu	-					
	abandoned in place						
	NFPA 72, Section	14.3.1 states that unless					
	otherwise permitted	d by 14.3.2, visual inspections					
	shall be performed	in accordance with the					
		14.3.1, or more often if required					
	by the authority hav	ving jurisdiction. Table 14.3.1					
	states that the follow	wing must be visually					
	inspected semi-ann	ually:					
	a. Control unit trou	ble signals					
	b. Remote annuncia						
	_	s (e.g. duct detectors, manual					
	fire alarm boxes, he	eat detectors, smoke detectors,					
	etc.)						
	d. Notification appl						
	e. Magnetic hold-op						
	_	ice could affect all occupants					
	in the facility.						
	Findings include:						
	Based on record rev	view on 09/14/22 between 10:00					
	a.m. and 1:15 p.m.	with the Director of					
	_	dministrator present, the most					
	recent four quarterl	•					
	1 .	-	- 1		I		I

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

Event ID:

inspection/testing reports dated 11/17/21, 02/22/22

(annual visual/functional inspection/test),

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Facility ID: 000304

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155525			ILDING	nstruction 01	(X3) DATE S COMPLI 09/14/2	ETED	
	ROVIDER OR SUPPLIER			36 VALI	DDRESS, CITY, STATE, ZIP COD LEY DR NCEBURG, IN 47025		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	E	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	equipped with 36 el detectors. The most sensitivity test dated electronically super facility. This was a discrepa supervised smoke d inspected or functio quarterly/annual insinterview, the Direct sensitivity test was alarm system vendo annual inspections. comparison of the remaintenance said senot included on the were located in clost missed by the correct This finding was reveniced.	nally tested during the four pection/test. Based on tor of Maintenance said the performed by a different fire r than the quarterly and When doing a side by side eports, the Director of everal of the smoke detectors quarterly and annual reports ets and must have been et vendor.					
	Maintenance and Acconference. 3.1-19(b)	dministrator during the exit					
K 0346 SS=F Bldg. 01	period, the authori be notified, and the evacuated or an a provided for all pa shutdown until the been returned to s 9.6.1.6	f Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the fire alarm system has ervice.	И 00		The plan of course they are "		10/02/2022
		iew and interview, the facility omplete written policy for the	K 03	346	The plan of correction constituthe written allegation of	tes	10/03/2022

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Event ID:

5IVX21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155525	B. WI	NG		09/14/	2022
				CTREET A	ADDRESS CITY STATE ZID COD		
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
CHADY		TD			LEY DR		
SHADI	NOOK CARE CENT	EK		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
	protection of 80 of	80 residents indicating			compliance for the deficiencies	s	
	procedures to be fo	llowed in the event the fire			cited. However, submission of	this	
	alarm system has to	be placed out of service for			plan of correction is not an		
	four hours or more	in a twenty four hour period in			admission that the deficiency		
	accordance with LS	SC, Section 9.6.1.6. This			exists or that one was cited		
	deficient practice affects all occupants in the				correctly. This plan of correction	on is	
	facility.				submitted to meet requiremen		
	idenity.				established by state and feder		
	Findings include:				law. Attached for your review		
	e				approval, is the completed pla		
	Based on record rev	view on 9/14/22 between 10:00			correction for the recent Life a		
	a.m. and 1:15 p.m. with the Director of				Safety Code Survey, Event ID		
	Maintenance and Administrator present, the				5IVX21, conducted on Septen		
	facility provided fire watch documentation from				14, 2022 at Shadynook Care		
		paredness plan, however, it			Center. Please be advised tha	ıt it	
		he plan did include the phone			is our intent to have this plan o		
	_	OH, however, the plan failed to			correction also serve as our		
		the Indiana Department of			allegation of compliance.		
		h the web link for contacting the			Compliance is effective Octob	er 3.	
	Incident Reporting	System located on the IDOH			2022. Shadynook Care Cente		
	Gateway, furthermo	ore, the fire watch did not			also respectfully requests a de		
	include documentat	tion to indicate the person			review for this plan of correction		
	conducting the fire	watch has been properly			K 0346		
	trained, and while o	conducting the fire watch that			It is the policy of Shadynook (Care	
	is the only duty/job	to be performed. Based on an			Center to provide a complete		
	interview at the tim	e of record review, the Director			written policy for the protection	າ of	
	of Maintenance and	Administrator confirmed the			residents, staff and visitors		
	fire watch lacked th	ne previously mentioned			indicating procedures to be		
	information.				followed in the event of the fire	9	
					alarm system being placed ou	t of	
	This finding was re	viewed with the Director of			service for four hours or more	in a	
	Maintenance and A	dministrator during the exit			twenty-four-hour period.		
	conference.				What corrective action will b	е	
					accomplished for those		
	3.1-19(b)				residents found to be affecte	:d	
					by the deficient practice?		
					No residents, staff or visitors v	vere	
					affected by the alleged deficie	nt	
					practice. A policy/procedure w		
					immediately revised to include		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155525		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD LEY DR	
SHADY N	NOOK CARE CENT	ER		ENCEBURG, IN 47025	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710	REGUENTURY OF	LEGG IDENTIFY THAT THE INTO THE ORIGINATION	1716	IDOH weblink for contacting to	
				incident reporting system loca	
				on the IDOH gateway. The po	olicy
				or procedure was also	
				immediately revised to include	9
				indication of the person	uot .
				conducting the fire watch in the they are properly trained and	
				person has this as their	u i i i
				designated sole responsibility	
				during the fire watch.	
				How other residents have th	e
				potential to be affected by the	ne
				same deficient practice will	be
				identified and what corrective	re
				action will be taken?	
				All residents, staff or visitors h	
				the potential to be affected by	
				alleged deficient practice. The corrective action for the defici	
				practice includes immediate	GIIL
				revision of the facility fire water	ch
				policy to include the IDOH	
				gateway weblink, ensuring pro	oper
				training of the designated fire	
				watch individual with	
				documentation of the fire water	ch
				being the only duty/job to be	
				performed.	10
				What measures will be put in place and what systemic	11.0
				changes will be made to	
				ensure that the deficient	
				practice does not recur?	
				The administrator or maintena	ance
				director/designee shall ensure	e that
				ensure that all	
				in-servicing/education is	
				completed on or by September	
			1	2022 of revisions to fire watch	ı

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SENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155525	B. WING		09/14/2022
SHADY	PROVIDER OR SUPPLIER	ER	36 VAL LAWRI	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0353	NFPA 101			policy. How will the corrective action be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the administrate maintenance director or design Maintenance Director or design will perform random audits for compliance when fire watches initiated.	or or Inee. Ignee
SS=B Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR	supply source RKS information on non-required or partial er system.			
	Based on observation failed to ensure the smoke compartmen	on and interview, the facility ceiling in 2 of 6 sprinklered ts was maintained to allow unction to their full capability.	K 0353	The plan of correction constitute written allegation of compliance for the deficiencie cited. However, submission o	es

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staff.

Event ID:

This deficient practice could affect 2 residents and

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If continuation sheet

plan of correction is not an

admission that the deficiency

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/14/2022	
		133323	D. WIN			09/14/	<u> </u>
	PROVIDER OR SUPPLIE			36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
	1		1		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
(X4) ID PREFIX TAG	Findings include: Based on observation p.m. and 4:00 p.m. the Director of Mathe following was a. 1 of 4 sprinkler breakroom was minaround the sprinkler breakroom was minaround the sprinkler breakroom was minaround the sprinkler but a for 2 sprinkler 20 was hanging on half inch gap around Based on interview observation, the Director of the previous finding was reconstructed.	ncy MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ons on 09/14/22 between 1:15 during a tour of the facility with intenance and Administrator,	F	ID PREFIX TAG	exists or that one was cited correctly. This plan of correctis submitted to meet requiremer established by state and fede law. Attached for your review approval, is the completed placorrection for the recent Life a Safety Code Survey, Event ID 5IVX21, conducted on Septer 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan correction also serve as our allegation of compliance. Compliance is effective Octob 2022. Shadynook Care Center dalso respectfully requests a direview for this plan of correcti K 0353 It is the policy of Shadynook Center that sprinklers are maintained in accordance with state and federal law. What corrective action will be accomplished for those residents found to be affected by the deficient practice? No residents, staff or visitors affected by the alleged deficient practice. Sprinkler escutcheor staff break room were replaced ensure no gap is around the sprinkler pipe to the interstitia space between the lower level.	on is nt ral and an of and of mber at it of esk on. Care he ed were ent ens in ed to I	(X5) COMPLETION DATE
					main level. The sprinkler escutcheon in resident room 2 was fixed to ensure it is not hanging and there is no gap around the sprinkler pipe to the attic.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED
		155525	B. WI	NG		09/14/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R			LEY DR	
SHADY	NOOK CARE CENT	TER			ENCEBURG, IN 47025	
OI I/(D1 I	TOOK OF ITE OLIV			L/WIK	LINGEBONG, IIV 47 020	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG		
					How other residents have the	
					potential to be affected by th	
					same deficient practice will t	
					identified and what correctiv	е
					action will be taken?	
					All residents, staff or visitors h	
					the potential to be affected by	
					alleged deficient practice. The	
					corrective action for the deficie	
					practice includes replacing an	
					fixing noted sprinklers in the s	
					break room and resident room	
					to comply with state and feder	al
					law.	
					What measures will be put in	ito
					place and what systemic	
					changes will be made to	
					ensure that the deficient	
					practice does not recur?	
					Audit completed by maintenar	
					director to ensure all sprinkler escutcheons are maintained in	
					accordance with state and fed	
					law. Audit to be completed by	
					maintenance director/designer	
					all sprinkler escutcheons weel	
					X4 weeks, then monthly ongo	-
					to ensure compliance.	"'9
					How will the corrective actio	n
					be monitored to ensure the	"
					deficient practice will not	
					recur?	
					The corrective actions will be	
					completed and overseen by the	ne
					maintenance director or desig	
			İ			
K 0354	NFPA 101					
SS=F	Sprinkler System	- Out of Service				
Bldg. 01	Sprinkler System					
-	1 .	ler system is impaired, the				

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155525	B. W	ING		09/14/	/2022
		.		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			LEY DR		
SHADVI	NOOK CARE CENT	FER			ENCEBURG, IN 47025		
OHADII				LAVVIXL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
		on of the impairment has					
		areas or buildings involved					
	· ·	l risks are determined,					
	recommendations						
	management or designated representative,						
	and the fire department and other authorities						
	having jurisdiction have been notified. Where						
	the sprinkler system is out of service for more						
		a 24-hour period, the					
		of the building affected are					
	evacuated or an approved fire watch is						
	1 3	sprinkler system has been					
	returned to servic						
		, 9.7.5, 15.5.2 (NFPA 25)					
		view and interview, the facility	K 0	354	The plan of correction constitu	tes	10/03/2022
	_	complete written policy			the written allegation of		
		res to be followed for the			compliance for the deficiencie		
	_	80 residents in the event the			cited. However, submission of	this	
	_	system has to be placed			plan of correction is not an		
		0 hours or more in a 24-hour			admission that the deficiency		
	_	ce with LSC, Section 9.7.5. LSC			exists or that one was cited		
		kler impairment procedures			correctly. This plan of correction		
		25, 2011 Edition, the Standard			submitted to meet requiremen		
	*	Testing and Maintenance of			established by state and feder		
		Protection Systems. NFPA 25,			law. Attached for your review		
	-	e procedures that the			approval, is the completed pla		
	_	nator shall follow. A.15.5.2 (4) ch should consist of trained			correction for the recent Life a	na	
	` '				Safety Code Survey, Event ID		
	_	tinuously patrol the affected			5IVX21, conducted on Septem	nber	
		to fire extinguishers and the			14, 2022 at Shadynook Care	4 :4	
		notify the fire department are consider. During the patrol of			Center. Please be advised that		
	^	0 1			is our intent to have this plan	DΤ	
	-	should not only be looking			correction also serve as our		
		sure that the other fire			allegation of compliance.	0	
		of the building such as egress			Compliance is effective Octob		
	I	stems are available and y. This deficient practice			2022. Shadynook Care Cente		
	~ · ·	•			also respectfully requests a de		
	could affect all occ	upants in the facility.			review for this plan of correction	DII.	
	Eindings in the 1				K 0354		
	Findings include:				It is the policy of Shadynook (Jare -	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		A. BUILDING B. WING	01	COMPLETED 09/14/2022	
	PROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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
	a.m. and 1:15 p.m. v. Maintenance and Adacility provided first the Emergency Prep was incomplete. The number for the IDO include contacting to Health (IDOH) with Incident Reporting Gateway, furthermore include documentate conducting the first trained, and while cois the only duty/job interview at the time of Maintenance and fire watch lacked the information.	iew on 9/14/22 between 10:00 with the Director of dministrator present, the e watch documentation from paredness plan, however, it he plan did include the phone H, however, the plan failed to the Indiana Department of the web link for contacting the System located on the IDOH are, the fire watch did not ion to indicate the person watch has been properly conducting the fire watch that to be performed. Based on an e of record review, the Director Administrator confirmed the e previously mentioned		Center to ensure there is a complete written policy contain procedures to be followed in the event the automatic sprinkler system has been placed out-of-service for 10 hours or in a twenty-four-hour period. What corrective action will be accomplished for those residents found to be affected by the deficient practice? No residents, staff or visitors was affected by the alleged deficient practice. A policy/procedure was immediately revised to include IDOH weblink for contacting the incident reporting system location on the IDOH gateway. The poor procedure was also immediately revised to include indication of the person conducting the fire watch in the they are properly trained, and person has this as their designated sole responsibility during the fire watch. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents, staff or visitors in the potential to be affected by alleged deficient practice. The corrective action for the deficient practice includes immediate revision of the facility fire watch policy to include the IDOH gateway weblink, ensuring protraining of the designated fire	more e e d were nt vas e the ne ted licy at that

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/14/2022
	ROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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
				watch individual with documentation of the fire wat being the only duty/job to be performed. What measures will be put i place and what systemic changes will be made to ensure that the deficient practice does not recur? The administrator or mainten director/designee shall ensure ensure that all in-servicing/education is completed on or by Septemb 2022 of revisions to fire watch policy. How will the corrective action be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the administrat maintenance director or designation and the deficient practice will be completed by the administration and the deficient practice or designation and the deficient practice will be completed by the administration and the deficient practice will be completed by the administration and the deficient practice will be completed by the administration and the deficient practice will be completed by the administration and the deficient practice will be completed by the administration and the deficient practice will be completed by the administration and the deficient practice will be defined by the definition and the deficient practice will be defined by the definition and the deficient practice will be defined by the definition and the deficient practice will be defined by the definition and the deficient practice will be defined by the definition and the deficient	ance e that er 30, n on or or gnee. gnee r
K 0361 SS=E Bldg. 01	treatment rooms a waiting areas, nur and cooking facilit in accordance with and 19.3.6.1. 18.3.6.1, 19.3.6.1	Open to Corridor In patient sleeping rooms, Ind hazardous areas), Ise's stations, gift shops, Ites, open to the corridor are In the criteria under 18.3.6.1			
	Based on observation	on and interview, the facility	K 0361	The plan of correction constit	utes 10/03/2022

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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 01 B. WING 09/14/2022 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 failed to ensure 2 of 2 areas in the basement/lower the written allegation of level open to the corridor were separated from the compliance for the deficiencies corridor by partitions capable of resisting the cited. However, submission of this passage of smoke as required in a sprinklered plan of correction is not an building, or met an Exception per 19.3.6.1(7). LSC admission that the deficiency 19.3.6.1(7) states that spaces other than patient exists or that one was cited sleeping rooms, treatment rooms, and hazardous correctly. This plan of correction is areas shall be open to the corridor and unlimited submitted to meet requirement in area, provided: (a) The space and corridors established by state and federal which the space opens onto in the same smoke law. Attached for your review and compartment are protected by an electrically approval, is the completed plan of supervised automatic smoke detection system in correction for the recent Life and accordance with 19.3.4, and (b) Each space is Safety Code Survey, Event ID protected by an automatic sprinklers, and (c) The 5IVX21, conducted on September space does not to obstruct access to required 14, 2022 at Shadynook Care exits. This deficient practice could affect staff Center. Please be advised that it only since residents do not go to the is our intent to have this plan of basement/lower level. correction also serve as our allegation of compliance. Findings include: Compliance is effective October 3. 2022. Shadynook Care Center Based on observations on 09/14/22 between 1:15 also respectfully requests a desk p.m. and 4:00 p.m. during a tour of the facility with review for this plan of correction. the Director of Maintenance and Administrator, K 0361 the following was noted: It is the policy of Shadynook Care a. The staff breakroom was open to the corridor Center to ensure that all areas without direct supervision from a 24 hour station open to corridor spaces are (i.e., Nurses' Station). protected by an electrically b. The large storage room in the basement was supervised automatic smoke open to the corridor without direct supervision detection system. from a 24 hour station (i.e., Nurses' Station). The What corrective action will be wall between the large storage room and the accomplished for those egress corridor only extended up from the floor residents found to be affected about 6 feet with an open area at the top 3 or 4 by the deficient practice? feet. No residents, staff or visitors were Furthermore, LSC 19.3.6.1(7) was not met because affected by the alleged deficient the staff breakroom and the large storage room in practice. A work order was the basement/lower level were not protected by an immediately initiated to ensure

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electrically supervised automatic smoke detection

system. Based on interview at the time of each

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installation of an electrically

supervised automatic smoke

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			` '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		01	COMPLETED
		155525	B. WING	G		09/14/2022
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
SHADY N	NOOK CARE CENT	ER	36 VALLEY DR LAWRENCEBURG, IN 47025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		rector of Maintenance said			detection system in the staff	
	residents do not cor				breakroom and the large stora	_
		el and agreed these areas were			room in the basement/lower le	vel.
	_	lectrically supervised			Completion of wired smoke	
		etectors or a full wall or door to			detector installation to be done	
	_	and was not directly			within 10 days or less than 10	
		hour station (i.e., Nurses'			days of submission of plan of	
	Station).				correction by vendor.	
	Th: - C. 1:				How other residents have the	
	_	viewed with the Director of dministrator during the exit			potential to be affected by th	
	conference.	diffinistrator during the exit			same deficient practice will be	
	conference.				identified and what correctiv action will be taken?	e
	3.1-19(b)				All residents, staff or visitors h	01/0
	3.1-19(0)				the potential to be affected by	
					alleged deficient practice. The	
					corrective action for the deficie	
					practice includes ensuring	7111
					electrically supervised automa	tic
					smoke detection systems are	
					installed in the staff breakroon	,
					and large storage room in the	'
					basement/lower level.	
					What measures will be put in	to .
					place and what systemic	
					changes will be made to	
					ensure that the deficient	
					practice does not recur?	
					The administrator and	
					maintenance director will ensu	ıre
					installation of electrically	
					supervised automatic smoke	
					detection systems to staff	
					breakroom and large storage i	room
					in basement/lower level.	
					Maintenance Director was	
					educated on the regulation	
					regarding electrically supervise	ed
					automatic smoke detection	
			1		systems	1

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTI A. BUILDI B. WING		NSTRUCTION 01	(X3) DATE : COMPL 09/14/	ETED
	ROVIDER OR SUPPLIER		36	3 VALL	DDRESS, CITY, STATE, ZIP COD EY DR NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IE PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using g complies with NFF Code, electrical wi complies with NFF Code. Existing ins service provided n 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 3 of provided with grour (GFCI) protection a 70, NEC 2011 Editi Circuit-Interrupter F states, ground-fault	Electric Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in to hazard to life. 9.1.1, 9.1.2 In and interview, the facility fover 20 wet locations, were ad fault circuit interrupter gainst electric shock. NFPA on at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for		AG	How will the corrective action be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the administrator and maintenance director or designee. Any areas of concer will be brought to the QA committee for review. The plan of correction constitute written allegation of compliance for the deficiencies cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited	n n tes s this	
	210.8(A) through (C circuit-interrupter sl accessible location. Informational Note: circuit interrupter prefeders. (B) Other Than Dw. single-phase, 15- an installed in the locat through (8) shall have	See 215.9 for ground-fault rotection for personnel on elling Units. All 125-volt, d 20-ampere receptacles ions specified in 210.8(B)(1)			correctly. This plan of correctic submitted to meet requirement established by state and federalaw. Attached for your review a approval, is the completed plan correction for the recent Life at Safety Code Survey, Event ID 5IVX21, conducted on Septem 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our	al and n of nd ber	

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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 COMPLETED 01 B. WING 09/14/2022 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 (1) Bathrooms allegation of compliance. (2) Kitchens Compliance is effective October 3. (3) Rooftops 2022. Shadynook Care Center (4) Outdoors also respectfully requests a desk Exception No. 1 to (3) and (4): Receptacles that are review for this plan of correction. not readily accessible and are supplied by a K 0511 branch circuit dedicated to electric snow-melting, It is the policy of Shadynook Care deicing, or pipeline and vessel heating equipment Center that equipment using gas shall be permitted to be installed in accordance or related to gas piping complies with 426.28 or 427.22, as applicable. with the national fuel gas code, Exception No. 2 to (4): In industrial establishments electrical wiring and equipment only, where the conditions of maintenance and complies with the national electric supervision ensure that only qualified personnel code are involved, an assured equipment grounding What corrective action will be conductor program as specified in 590.6(B)(2) accomplished for those shall be permitted for only those receptacle residents found to be affected outlets used to supply equipment that would by the deficient practice? create a greater hazard if power is interrupted or No residents, staff or visitors were having a design that is not compatible with GFCI affected by the alleged deficient protection. practice. A GFCI outlet was (5) Sinks - where receptacles are installed within immediately installed to the 1.8 m (6 ft.) of the outside edge of the sink. electric receptacle in the activity Exception No. 1 to (5): In industrial laboratories, office located near the sink. A receptacles used to supply equipment where GFCI outlet was immediately removal of power would introduce a greater installed to the C Hall bathroom hazard shall be permitted to be installed without near the sink. A GFCI was GFCI protection. immediately installed to the Exception No. 2 to (5): For receptacles located in electric receptacle in the beauty patient bed locations of general care or critical salon near the sink. care areas of health care facilities other than those How other residents have the covered under potential to be affected by the 210.8(B)(1), GFCI protection shall not be required. same deficient practice will be (6) Indoor wet locations identified and what corrective (7) Locker rooms with associated showering action will be taken?

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facilities

electrical

(8) Garages, service bays, and similar areas where

receptacles and fixed equipment within the area of

diagnostic equipment, electrical hand tools.

NFPA 70, 517-20 Wet Locations, requires all

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All residents, staff or visitors have

the potential to be affected by the

corrective action for the deficient

alleged deficient practice. The

practice includes installation of

guard-fault circuit interrupter

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/14/2022		
		ROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
		SUMMARY: (EACH DEFICIEN REGULATORY OR the wet location to l interrupter (GFCI) preduce the contact r electrical insulation This deficient pract residents and staff. Findings include: Based on observation p.m. and 4:00 p.m. of the Director of Main the following was in a. The electric rece was within two feet provided with a GFCI the electrical circuit b. The C Hall bath receptacle within two provided with a GF however, when test the electric circuit v device showed the r Hot/Neutral Revers c. The electric rece four feet of the coun with a GFCI protect with a GFCI testing electrical circuit. Based on interview observation, the Dir the previously ment GFCI protected.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION have ground-fault circuit protection. Note: Moisture can esistance of the body, and is more subject to failure. ice could affect at least 2 ons on 09/14/22 between 1:15 during a tour of the facility with intenance and Administrator, oted: ptacle in the Activity Office of the sink and was not CI protected receptacle. When testing device, it did not break is coom had one electric for feet of the sink that was CI protected receptacle, ed with a GFCI testing device, was not broken. The testing receptacle to be wired e. ptacle in the Salon was within inter sink and was not provided ted receptacle. When tested is device, it did not break the			Hall nto a ions with ock. the nee n e as of
		_	dministrator during the exit			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/14/2022	
	PROVIDER OR SUPPLIER		36 VAL	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 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
K 0521 SS=C Bldg. 01	comply with 9.2 ar accordance with the specifications. 18.5.2.1, 19.5.2.1, Based on observation failed to ensure egree a portion of a return rooms for 47 of 47 regress corridors. Les conditioning, heating related equipment to with NFPA 90A, the of Air Conditioning NFPA 90A, Section corridors in nursing shall not be used as or exhaust air system unless otherwise per 4.3.12.1.3.4. This does not be used as Findings include: Based on observation p.m. and 4:00 p.m. of Maintenance and rooms were using the air system. Based conservations, the Achas an existing Life resident sleeping rocorridors were being system.	on and interview, the facility ess corridors were not used as a air system serving adjoining resident rooms and 5 of 5 SC 9.2.1 requires air ag, ventilating ductwork and to be installed in accordance estandard for the Installation and Ventilating Systems. 14.3.12.1.1 states egress and long term care facilities a portion of a supply, return, an serving adjoining areas rmitted by 4.3.12.1.3.1 through efficient practice could affect all	K 0521	Please see attached Life & sar waiver request form. The facility has been granted a waiver for K021 each year sind 1990, when the tag was first of Following the 1990 survey, the facility had installed a system whereby the activation of the falarm, including the automatic sprinkler system and the automatic smoke detection was shut down the supply air fans. In 1990, the facility obtained a estimate from a contractor to install return air ducts in each residents room. The cost at the time was approximately \$29,782.00. All fire protection devices tested by Safe Care on an annual base Sprinkler system tested by Safe Care quarterly. Facility maintenance conducts fire drill quarterly on shifts (1) and (2) walarm is tripped.	a ce ited. e ire ould n at ed sis. fe
	Maintenance and A	dministrator during the exit			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155525	B. W	WING 09/14/202		/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			LEY DR		
SHADY	NOOK CARE CENT	FR			ENCEBURG, IN 47025		
OHADII	TOOK OF WE OUT			L/\VVI\L	11025010, 111 47 020		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conference.						
	3.1-19(b)						
14.05.44							
K 0541	NFPA 101						
SS=E		ncinerators, and Laundry					
Bldg. 01	Chu						
		ncinerators, and Laundry					
	Chutes						
	2012 EXISTING						
	1 ' '	nen and trash chute,					
		tic rubbish and linen					
	systems, that opens directly onto any corridor shall be sealed by fire resistive						
		event further use or shall be					
		e door assembly having a					
	1 '	ng of 1-hour. All new chutes					
	shall comply with	~					
		o.o. nute or linen chute,					
	1 ' '	tic rubbish and linen					
		provided with automatic					
	l -	ection in accordance with					
	9.7.	Solien in accordance with					
		e shall discharge into a					
		om used for no other					
		ected in accordance with					
	1 ' '	dry chutes permitted to					
		ne room are protected by					
		ers in accordance with					
	19.3.5.9 or 19.3.5						
	(4) Existing fuel-fe	ed incinerators shall be					
	sealed by fire resi	stive construction to prevent					
	further use.	•					
	19.5.4, 9.5, 8.4, N	FPA 82					
		ration and interview, the	K 0	541	The plan of correction constitu	ıtes	10/03/2022
	facility failed to ma	intain 1 of 1 laundry chute door			the written allegation of		
		ing and positive latching. LSC			compliance for the deficiencie	:S	
		chutes shall be installed and			cited. However, submission of	f this	
		PA 82, 2009 Edition. NFPA 82			plan of correction is not an		
	5.2.3.3.1.1 requires	all chute loading doors into a			admission that the deficiency		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155525	B. WING		09/14/2022		
			STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	R		LEY DR			
SHADY N	NOOK CARE CENT	TER		LAWRENCEBURG, IN 47025			
	T			T			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA			
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE		
		provided with a self-closing,		exists or that one was cited			
	-	ame and gasketed door		correctly. This plan of correcti	I		
		icient practice could affect over		submitted to meet requiremen			
	10 residents, as wel	ll as staff and visitors.		established by state and feder	I		
	T. 1			law. Attached for your review	I		
	Findings include:			approval, is the completed pla			
		00/44/901		correction for the recent Life a			
		on on 09/14/22 between 1:15		Safety Code Survey, Event ID			
		during a tour of the facility with		5IVX21, conducted on Septen	nber		
		intenance and Administrator,		14, 2022 at Shadynook Care			
		dry chute door was not fully		Center. Please be advised that			
	_	ould not close completely and		is our intent to have this plan	of		
	latch into its frame.			correction also serve as our			
		or was opened fully it would		allegation of compliance.	_		
		n. When tested further, the		Compliance is effective Octob			
	-	oushed closed completely.		2022. Shadynook Care Cente			
		ch gap between the door and		also respectfully requests a de	I		
		n interview at the time of		review for this plan of correction	on.		
		rector of Maintenance agreed		K 0541			
		oor did not operate as		It is the policy of Shadynook			
	designed.			Center to ensure that the laun	-		
	TTI : C' 1'			chute/linen system is provided	I		
	_	eviewed with the Director of		with automatic fire extinguishi	ng		
		dministrator during the exit		protection.			
	conference.			What corrective action will b	e		
	2.1.10(1-)			accomplished for those			
	3.1-19(b)			residents found to be affected	ea		
	2 D1	4:		by the deficient practice?			
		vation and interview, the		No residents, staff or visitors v			
	· ·	sure 1 of 1 soiled linen chute		affected by the alleged deficie			
	_	automatic extinguishing dance with LSC 9.7. LSC		practice. The facility ensured the laundry shuts door energy			
				the laundry chute door operat	es		
		ach automatic sprinkler system		effectively; ensuring that it	h		
		r section of this code shall be		self-closes, has a positive late	I		
		NFPA 13, Standard for the		and is a gasketed door. A wor			
	•	nkler Systems. NFPA 13, 2010		order was immediately create			
		.15.2.2.1.1 states gravity chutes		have a sprinkler installed to m	I		
	•	nternally by automatic		compliance of state and feder	aı		
	sprinklers unless th	ey are lined in accordance with		law.			

Section 5.2.2.6.1 in NFPA 82, Standard on

How other residents have the

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	T OF HEALTH AND HU						RM APPROVED	
	R MEDICARE & MEDI		(2/2) 1/0	III TIDI E C	ONCERLICEION		MB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>			
		155525	B. WI	NG _		09/14/2022		
NAME OF	DD OVIDED OD GUDDI II	Z.D.		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	SR.		36 VAI	LLEY DR			
SHADY	NOOK CARE CEN	TER		LAWR	AWRENCEBURG, IN 47025			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Incinerators and W	Vaste and Linen Handling			potential to be affected by t	he		
	Systems and Equip	pment, 2009 Edition. This			same deficient practice will			
	protection requires	s that a sprinkler be installed at			identified and what correcti			
	or above the top so	ervice opening of the chute.			action will be taken?			
	_	ers installed in gravity chute			All residents, staff or visitors	have		
	1 ^	hall be recessed out of the			the potential to be affected b			
		which the material travels. In			alleged deficient practice. Th	-		
		er shall be installed within the			corrective action for the defic			
	chute at alternate floor levels in buildings over two stories in height, with a mandatory sprinkler located at the lowest service level. This deficient practice could affect 1 or more staff in the vicinity				practice includes that the line			
					system/laundry system opera			
					with a self-closing, positive la			
					gasketed door and that a spr			
	_	chute on the main level, plus			is installed to meet complian			
		e vicinity of the soiled linen			state and federal law. Instilla			
	room.	e vienney of the soned inten			sprinkler at the laundry chute			
	Toom.				system.	,/III ICI I		
	Findings include:				What measures will be put	into		
	i manigs merade.				place and what systemic	iiito		
	Rosed on observat	ions on 09/14/22 between 1:15			changes will be made to			
		during a tour of the facility with			ensure that the deficient			
		nintenance and Administrator,						
		ute between the main level and			practice does not recur? The maintenance director to			
		vel was not equipped with an			complete an audit of the laur	dnı		
		er in the chute. Based on			· ·	•		
	_	ne of the observation, the			chute door to ensure that it h	as a		
					self-closing, positive latch	alia		
		enance agreed an automatic			gasketed door weekly X4 we	eks		
	1 -	t be located within the soiled			then monthly to ensure	_		
	linen chute.				compliance. The maintenance			
	Th: - C. 1	and and distribute D' of C			director to ensure the sprinkl			
	_	eviewed with the Director of			installed remains in place an	a		
		Administrator during the exit			working condition to meet			
	conference.				compliance.			
					How will the corrective acti			
	3.1-19(b)		1		be monitored to ensure the			
					deficient practice will not			
					recur?			
					The corrective actions will be	:	1	

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completed by the maintenance director or designee. Any areas of concern will be brought to the QA

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DEPARTMENT OF HEALTH AND HUMAN SE	CRVICES
CENTERS FOR MEDICARE & MEDICAID SE	RVICES

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	ľ í	JILDING	instruction 01	(X3) DATE : COMPL 09/14 /	ETED
	PROVIDER OR SUPPLIER			36 VALI	ADDRESS, CITY, STATE, ZIP COD LEY DR NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	TE	(X5) COMPLETION DATE
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are persent informed with and a copy of the with telephone opplan addresses the of staff per 18/19.2 of the fire safety persent informed in 18/19.2.2. 18.7.1.1 through 19.7.2.1.2, 19.7.2.3 19.7.2.1.2, 19.7.2.1.2 Based on record reversited to provide a converted for the fire safety persent information in 19.7.2.2. LSC 19.7 occupancy fire safety persent information in 19.7.2.2. LSC 19.7 occupancy fire safety persent in 19.7.2.2. Isolation of fire (6) Evacuation of fire (6) Evacuation of fire (7) Evacuation of fire vacuation (9) Extinguishment Section 19.2.3.4(4)	elocation Plan plan for the protection of all eir evacuation in the event riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 riew and interview, the facility complete facility specific lan for the protection of 80 of rately address all life safety em addressing all items 101, 2012 edition, Section 1.2.2 requires a written health care try plan that shall provide for alarm to fire department the call to fire department me can building for	K 0	711	The plan of correction constitute the written allegation of compliance for the deficiencies cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correctic submitted to meet requirement established by state and feder law. Attached for your review approval, is the completed placorrection for the recent Life a Safety Code Survey, Event ID 5IVX21, conducted on Septem 14, 2022 at Shadynook Care Center. Please be advised that is our intent to have this plan of correction also serve as our allegation of compliance. Compliance is effective October	s this on is t all and n of nd hber t it	10/03/2022

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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 01 COMPLETED B. WING 09/14/2022 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 width where serving as means of egress from 2022. Shadynook Care Center patient sleeping rooms. Projections into the also respectfully requests a desk required width shall be permitted for wheeled review for this plan of correction. equipment provided the relocation of wheeled K 0711 equipment during a fire or similar emergency is It is the policy of Shadynook Care addressed in the written fire safety plan and Center to ensure that there is an training program for the facility. The wheeled evacuation written plan for all equipment is limited to: residents, staff and visitors for i. Equipment in use and carts in use their evacuation in the event of an ii. Medical emergency equipment not in use emergency. iii. Patient lift and transport equipment What corrective action will be This deficient practice could affect all occupants accomplished for those in the event of an emergency. residents found to be affected by the deficient practice? Findings include: No residents, staff or visitors were affected by the alleged deficient Based on a review of the facility's "Fire practice. The facility ensured that Procedures" on 09/14/22 between 10:00 a.m. and the emergency evacuation plan 1:15 p.m. with the Director of Maintenance and was revised to include verbiage Administrator present, the plan did not address stating that a backup call to 9-1-1 the following items: be placed after the fire alarm has a. A back up call to 9-1-1 after the fire alarm has been activated. Plan and policy been activated revision to include staff response b. Staff response to battery powered smoke to battery powered smoke alarms alarms located in resident sleeping rooms. located in resident sleeping c. The use of the K-class fire extinguisher in the rooms. Plan and policy revision to kitchen in relationship with the use of the kitchen include the use of the K-class fire overhead extinguishing system. extinguisher in the kitchen in d. The removal of wheeled equipment from the relationship with the use of the corridor in the event of an emergency. overhead extinguishing system. Furthermore, it was stated at "4. Fire in Plan and policy revision to include Operational Areas, A. Kitchen: d. Evaluate the removal of wheeled equipment severity to determine if automatic stove from the corridor in the event of an extinguisher is required (may result in greater emergency. Plan and policy damage and clean-up.)" revision to remove "determination Based on interview at the time of record review, of severity level if stove

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the Director of Maintenance acknowledged and

agreed that the fire safety plan did not address the

previously mentioned items and the #4 statement

concerning the automatic stove extinguishment

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extinguisher is required as this

use of stove extinguisher

may result in greater damage and

clean-up." Plan and policy to add

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155525	B. W	NG		09/14/	/2022
				CERTE	ADDRESS SITU STATE THE SOR		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
OLIA DV	NOOK OADE OEN	TED			LEY DR		
SHADY	NOOK CARE CEN	IER		LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	should either be co	orrected or removed.			immediately.		
					How other residents have th	е	
	This finding was r	eviewed with the Director of			potential to be affected by th	ie	
	Maintenance and A	Administrator during the exit			same deficient practice will I	ре	
	conference.				identified and what corrective	e	
					action will be taken?		
	3.1-19(b)				All residents, staff or visitors h	ave	
					the potential to be affected by	the	
					alleged deficient practice. The	!	
					corrective action for the defici-	ent	
					practice includes evacuation p	olan	
					and policy revision to ensure		
					calling 9-1-1 as back up once		
					alarm activation has occurred	,	
					staff response to battery power	ered	
					smoke alarms located in resid	ent	
					sleeping rooms, K-class		
					extinguisher use, removal of		
					wheeled equipment from corri	dors	
					and removal of verbiage from		
					evacuation plan "determinatio	n of	
					level of severity" associated w	rith	
					stove extinguisher.		
					What measures will be put in	nto	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?	_	
					The administrator ensured that		
					staff were educated on the rev		
					evacuation plan/procedure be	tore	
					or on September 30, 2022.		
					(Attachment B) All new		
					employees will undergo training	-	
					during general orientation whi		
					will include the language of th		
					revised evacuation plan. All st	aff to	
					maintain ongoing education		
					according to policy of facility.		
I	1		1		How will the corrective actio	n	l

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2022	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD LLEY DR		
SHADY I	NOOK CARE CENT	ER		ENCEBURG, IN 47025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAU	REGULATORY OR	LISC IDENTIFY FING INFORMATION	TAG	be monitored to ensure the deficient practice will not recur? The corrective actions will be completed by the administrate maintenance director or desig Any areas of concern will be brought to the QA committee review.	or or nee.	
K 0712 SS=C Bldg. 01	alarm signal and so conditions. Fire drand unexpected ti conditions, at least The staff is familia aware that drills a routine. Where drawine. Where drawine and 6:00 announcement mandible alarms.	ay be used instead of 9.7.1.7				
	failed to ensure fire for 1 of 3 employee This deficient pract the facility. Findings include: Based on review of on 09/14/22 betwee the Director of Main present, three of for drills were performe p.m. Based on interpresent.	the facility's fire drill reports in 10:00 a.m. and 1:15 p.m. with intenance and Administrator ir, second shift (evening) fire ed between 6:20 p.m. and 6:35 review at the time of record of Maintenance and	K 0712	The plan of correction constitute the written allegation of compliance for the deficiencie cited. However, submission of plan of correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correctis submitted to meet requirement established by state and feder law. Attached for your review approval, is the completed plat correction for the recent Life at Safety Code Survey, Event ID 5IVX21, conducted on Septem	s in this on is t ral and n of ind	

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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. BUILDING <u>01</u>		01	COMPLETED	
		155525	B. WING		09/14/	2022	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
CHADYA	JOOK CARE CENT	TED			LEY DR		
SHADY	NOOK CARE CENT	ER		LAWKE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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	
	Administrator acknowledged the times of the				14, 2022 at Shadynook Care		
	second shift fire drills were performed and agreed				Center. Please be advised tha	ıt it	
	the times were not varied enough.				is our intent to have this plan o	of	
	, and the second				correction also serve as our		
	This finding was reviewed with the Director of				allegation of compliance.		
	Maintenance and Administrator during the exit			Compliance is effective Oc		er 3.	
	conference.			2022. Shadynook Care Center		r	
					also respectfully requests a desk		
	3.1-19(b)				review for this plan of correction	on.	
					K 0712		
					It is the policy of Shadynook (Care	
					Center to ensure that fire drills	;	
					include the transmission of a f	ire	
					alarm signal and simulation of		
					emergency fire conditions. To		
					ensure fire drills are held at		
					expected and unexpected time	es	
					under varying conditions, at le	ast	
					quarterly on each shift.		
					What corrective action will b	е	
					accomplished for those		
				residents found to be affected			
					by the deficient practice?		
					No residents, staff or visitors v		
					affected by the alleged deficie		
					practice. Quarterly fire drills to		
					completed at varied times. Sta	att	
					will remain familiar with		
					procedures and are aware tha	ΙT	
					drills are part of the facility	-1	
					established routine, however,		
					will be tailored to not be expect		
					at same time frame in order to	1	
					simulate an emergency.		
					How other residents have the		
					potential to be affected by th		
					same deficient practice will be		
					identified and what correctiv	е	
					action will be taken?		
			1		All residents, staff or visitors h	ave	

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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. BUILDING <u>01</u>		01	COMPLETED	
		155525	B. WING			09/14/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			LEY DR		
SHADY NOOK CARE CENTER			LAWRENCEBURG, IN 47025				
(X4) ID	SUMMARY	MARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION					DATE
					the potential to be affected by		
					alleged deficient practice. The		
			corrective action for the de				
			practice includes ensuring that al				
				quarterly fire drills are scheduled		iea	
					to be varied in time to ensure simulation of emergency.		
					What measures will be put in	nto	
					place and what systemic	110	
			changes will be made to				
					ensure that the deficient		
					practice does not recur?		
			The administrator or designee will				
				complete audit of all quarterly fire			
				drills to ensure time has variance			
			to simulate emergency, in that				
		staff will not be expectant of					
		"timed" drill but rather only					
				expectant of fire drills being a part			
				of facility established routine.			
				How will the corrective action			
					be monitored to ensure the		
					deficient practice will not		
					recur?		
					The corrective actions will be		
					completed by the administrate		
					designee. Any areas of conce	rn	
					will be brought to the QA		
1	I		1		committee for review		ĺ

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