11/08/2024

			PRINTED: 11/00			
EPARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDIC	CAID SERVICES		OMB NO. 0938-03			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
	155022	B WING	10/21/2024			

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2309 S MILLER ST WILLOWS OF SHELBYVILLE SHELBYVILLE, IN 46176 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 Preparation and/or execution conducted by the Indiana Department of Health in of this Plan of Correction does accordance with 42 CFR 483.73. not constitute admission or agreement by the provider of Survey Date: 10/21/24 the truth of the facts alleged or conclusions set forth in the Facility Number: 000009 statement of deficiencies. The Provider Number: 155022 Plan of Correction is prepared AIM Number: 100274760 and/or executed solely because is required by the At this Emergency Preparedness survey, The provisions of Federal and State Willows of Shelbyville was found in compliance Law. with Emergency Preparedness Requirements for /b> Medicare and Medicaid Participating Providers /b> and Suppliers, 42 CFR 483.73. The facility has 141 certified beds. At the time of the survey, the census was 60. Quality Review completed on 10/23/24 K 0000 Bldg. 01 A Life Safety Code Recertification and State K 0000 Preparation and/or execution Licensure Survey was conducted by the Indiana of this Plan of Correction does Department of Health in accordance with 42 CFR not constitute admission or 483.90(a). agreement by the provider of the truth of the facts alleged or Survey Date: 10/21/24 conclusions set forth in the statement of deficiencies. The Facility Number: 000009 Plan of Correction is prepared Provider Number: 155022 and/or executed solely AIM Number: 100274760 because is required by the provisions of Federal and State At this Life Safety Code survey, The Willows of Law.

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

Shelbyville was found not in compliance with

TITLE (X6) DATE

Mandi Paul **HFA** 11/01/2024

/b>

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

Event ID: HEE021 000009 Page 1 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete Facility ID: If continuation sheet

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO.			IB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155022	B. W	NG		10/21/	/2024	
				CTREET	ADDRESS STATE ZID COD			-
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD			
\A/II I O\A	/O OF OUEL DV///	ı.e.			MILLER ST			
WILLOW	/S OF SHELBYVIL	LE		SHELB	YVILLE, IN 46176			
(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 APPROPRIATI	F	COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Requirements for	Participation in			/b>			
	Medicare/Medicai	d, 42 CFR Subpart 483.90(a),						
		Fire and the 2012 edition of the						
		ection Association (NFPA) 101,						
		(LSC), Chapter 19, Existing						
		pancies and 410 IAC 16.2.						
	This one story faci	ility was surveyed as one						
		uilding of Type $V(000)$ construction and was						
fully sprinklered. The facility has a fire alarm								
	system with smoke detection in the corridors and in all areas open to the corridor. The facility has							
battery operated smoke detectors installed in all								
		rooms. The facility has a						
		d had a census of 60 at the time						
	of this visit.							
	A 11 1	21 4 1						
		sidents have customary access						
	_	and all areas providing facility						
	services were sprii	nklered.						
	o ti p	1 . 1 . 10/02/04						
	Quality Review co	ompleted on 10/23/24						
K 0211	NEDA 404							
SS=E	NFPA 101	0						
	Means of Egress	s - General						
Bldg. 01	Dagad on alegamiet	ion and interview the facility	17.0	211	\A/b at a sum ative a ation (a) will be	_	11/00/2024	
		ion and interview, the facility of over 4 corridor means of	K 0	211	What corrective action(s) will be		11/08/2024	
					accomplished for those residen			
	_	tinuously maintained free of			found to have been affected by	tne		
		19.2.3.4 (4) states projections			deficient practice?			
	_	width shall be permitted for			1.			
		nt, provided that all of the			15 residents had the potential t			
	following condition				be affected, none were. The P			
		quipment does not reduce the			cart was removed and replaced	t		
		corridor width to less than 60			with a wheeled cart.			
	in.(1525 mm).							
		e occupancy fire safety plan and			How other residents having the	;		
	I training program a	address the relocation of the			potential to be affected by the		1	

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

emergency.

wheeled equipment during a fire or similar

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

same deficient practice will be

identified and what corrective

Page 2 of 20

CENTERS FOR MEDICARE & MEDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155022 B. WING 10/21/2024 STREET ADDRESS, CITY, STATE, ZIP COD

NAME OF PROVIDER OR SUPPLIER 2309 S MILLER ST

WILLOWS OF SHELBYVILLE			2309 S MILLER ST SHELBYVILLE, IN 46176		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECEDENT ATTOMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION (c) The wheeled equipment is limited to the	TAG	action(s) will be taken?	DATE	
	following: i. Equipment in use and carts in use		While all residents have the		
	ii. Medical emergency equipment not in use		potential to be affected none		
	iii. Patient lift and transport equipment		were. Facility reviewed all egress		
	This deficient practice affects 15 residents in the		to assure no obstructions and/or		
	facility.		wheeled equipment was appropriate.		
	Findings include:		3,4,5,4,000		
			What measures will be put into		
	Based on observations and interviews during a		place and what systemic changes		
	tour of the facility with the Maintenance Director		will be made to ensure the		
	(MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., in all resident hall corridor near RR# 110 a		deficient practice does not recur?		
	Personal Protective Equipment (PPE) cart was in		Maintenance Director and Medical		
	use but not equipped with wheels allowing the		Records was educated on facility		
	cart to be moved out of the hall during an		requirement. The PPE cart was		
	emergency.		removed and replaced with a		
	This finding was acknowledged by the		wheeled cart. Facility reviewed all		
	Maintenance Director at the time of discovery and		egress to assure no obstructions		
	again at the exit conference with the		and/or wheeled equipment was		
	Administrator, Reginal Representative and the Maintenance Director present.		appropriate.		
			How the corrective action(s) will be		
	3.1-19(b)		monitored to ensure that the		
			deficient practice will not recur.		
			I.e., what Quality Assurance		
			program will be put into place?		
			The maintenance supervisor or		
			designee will monitor ways of		
			egress for obstructions and/or		
			wheeled equipment are		
			appropriate weekly for 4 weeks		
			then monthly x 6months. The		
			Quality Assurance and		
			Performance Improvement		
			committee will review results of		
			the findings during the monthly		
			facility QA meeting for at least 6		
	•		•	•	

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

Event ID:

HEE021 Facility ID: 000009

If continuation sheet

Page 3 of 20

ľ		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155022	B. WING 10/21/2024			2024	
NAME OF P	PROVIDER OR SUPPLIER		•	STREET .	ADDRESS, CITY, STATE, ZIP COD		
			2309 S MILLER ST				
WILLOW	S OF SHELBYVILL	E		SHELBYVILLE, IN 46176			
(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	LSC IDENTIFYING INFORMATION		TAG	months. At the end of the 6-		DATE
					month period the QA team ma		
					opt to discontinue the review of		
					data during the meeting if	"	
					compliance is evident		
					compilation is evident		
K 0222	NFPA 101						
SS=F	Egress Doors						
Bldg. 01							
	Based on observation	on and interview, the facility	K 0	222	What corrective action(s) will be	ре	11/08/2024
	failed to ensure 1 of	Fover 8 exterior exit doors were			accomplished for those reside	nts	
	readily accessible, n	not blocked and able to open			found to have been affected b	y the	
	on first try. This def	ficient practice could affect all			deficient practice?		
	occupants in the fac	ility.					
					All occupants had the potentia	al to	
	Findings include:			be affected, none were. The			
			sandbags were removed.				
		ons and interviews during a					
		with the Maintenance Director			How other residents having th		
	· /	between 11:30 a.m. and 2:45		potential to be affected by			
	-	t doors on Station 2 east hall		same deficient practice will		·	
	_	to 8 large sandbags being			identified and what corrective		
		and outside the doors. The			action(s) will be taken?		
	-	oved during the survey, and it					
	was verified the doc	ors would open.			While all occupants have the		
	TL:- £ 1'	h			potential to be affected none	.	
	This finding was ac	· ·			were. Facility reviewed all exi		
		or at the time of discovery and			doors to assure no obstruction	is or	
	again at the exit con				locks were in use.		
		nal Representative and the			\\/\ _\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
	Maintenance Direct	or present.			What measures will be put into		
	2 1 10/b)				place and what systemic chan	iges	
	3.1-19(b)				will be made to ensure the		
					deficient practice does not rec	ur?	

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

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

Page 4 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155022		A. BUILDING B. WING	01	COMPLETED 10/21/2024	
	ROVIDER OR SUPPLIER		2309 S	ADDRESS, CITY, STATE, ZIP COD MILLER ST BYVILLE, IN 46176	
(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
	REGULTION			Maintenance Director was educated on facility requirement The sandbags were removed, facility reviewed all exit doors assure no obstructions or lock were in use. How the corrective action(s) were in use. The will not recur it.e., what Quality Assurance program will be put into place? The maintenance supervisor of designee will monitor exit door obstructions and/or locks were for 4 weeks then monthly x 6months. The Quality Assuration and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least months. At the end of the 6-meriod the QA team may opt to discontinue the review of data during the meeting if compliant is evident	ent. to s vill be r. ? or rs for kly nce nt of y 6 onth o
K 0271 SS=E Bldg. 01		on and interview, the facility	K 0271	What corrective action(s) will b	•
	tailed to ensure 1 of	f over 8 exit discharges was		accomplished for those reside	nts

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

Event ID:

HEE021 Facility ID: 000009

If continuation sheet

Page 5 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155022	(X2) MULTIPLE A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 10/21/2024
	ROVIDER OR SUPPLIER S OF SHELBYVILL		2309	T ADDRESS, CITY, STATE, ZIP COD S MILLER ST BYVILLE, IN 46176	
(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
		This deficient practice could f and any residents being his door.		found to have been affected deficient practice?	d by the
	Findings include: Based on observation tour of the facility with	ons and interviews during a with the Maintenance Director between 11:30 a.m. and 2:45 schen exit, marked a facility exit, arked a truck on the exit ag clear width of travel to the D agreed and stated he was beyoe vehicle stating they ll a no parking sign. knowledged by the for at the time of discovery and afterence with the smal Representative and the		8 dietary employees had the potential to be affected, nor were. The vehicle was immediately removed. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken? While all occupants have the potential to be affected none. The vehicle was immediate removed, and all other exiting pathways were reviewed. So purchased and installed to a NO PARKING. What measures will be put in place and what systemic chewill be made to ensure the deficient practice does not a management of the was purchased and installed note NO PARKING. How the corrective action(so monitored to ensure that the deficient practice will not really the program will be put into place.	the he be ve e were. lly sign was note into langes recur? ated all sign d to) will be e cur. e
				The maintenance supervisor designee will monitor all exi	

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

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

Page 6 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155022		A. BUILDING <u>01</u> COM		COMPLETED 10/21/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2309 S MILLER ST SHELBYVILLE, IN 46176			
(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 0293 SS=E Bldg. 01	failed to ensure 1 of the facility were not LSC 7.10.8.3.1 state stairway that is neitl access and that is lool likely to be mistaked by a sign that reads EXIT sign shall havinches high, with a sand the word EXIT such sign is an approdeficient practice coeffindings include: Based on observation	on and interview, the facility fover 8 doors to the outside of mistaken as a facility exit. es any door, passage, or her an exit nor a way of exit cated or arranged so that it is in for an exit shall be identified as follows: NO EXIT. The NO e the word NO in letters 2 estroke width of 3/8ths inch, below the word NO, unless below the word NO in letters 2 estroke width of 3/8ths inch, below the word NO, unless below the word NO in letters 2 estroke width of 3/8ths inch, below the word NO in letters 2 estroke width of 3/	K 0293	pathways for clear accessibility weekly x 4 weeks and monthly months. The Quality Assurant and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least months. At the end of the 6-mayeriod the QA team may opt to discontinue the review of data during the meeting if compliant is evident. What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice? 13 residents had the potential be affected, none were. The estign chevron was updated to adhere to the correct exit passageway. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? While all occupants have the	y x 6 ce of y 6 conth co ce 11/08/2024 to exit e	

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

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

Page 7 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155022	(X2) MULTIP A. BUILDIN B. WING	le construction ng <u>01</u>	-	ESURVEY LETED //2024
	ROVIDER OR SUPPLIER		230	REET ADDRESS, CITY, STATE, ZIP CO. 09 S MILLER ST IELBYVILLE, IN 46176	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREF TAG	G CROSS-REFERENCED TO THE API	OULD BE PROPRIATE	(X5) COMPLETION DATE
	p.m., the exit sign of Entrance was points was no longer access of the facility. The a new permanent we from the area describe chevron arrow is be corrected. This finding was accommand the exit contagain at the exit con	or at the time of discovery and afterence with the		potential to be affected in The exit sign chevron we to adhere to the correct passageway. All other existence for deficient provided and what systemic will be made to ensure the deficient practice does in	as updated exit exits were actice. out into c changes he	
	Administrator, Reg Maintenance Direct 3.1-19(b)	inal Representative and the or present.		Maintenance director was educated on exit and dir signs. The exit sign chew updated to adhere to the exit passageway. All off were reviewed for deficient practice. How the corrective action monitored to ensure that deficient practice will not lie., what Quality Assuration program will be put into	rectional vron was e correct her exits ent on(s) will be t the t recur. ance place?	
				designee will monitor all directional signs monthly 6months. The Quality As and Performance Improvement of the findings during the manifect findings during for a months. At the end of the period the QA team manifect findings the meeting if corrections is evident	y x ssurance vement sults of nonthly t least 6 e 6-month y opt to of data	

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

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

Page 8 of 20

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155022		,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/21/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2309 S MILLER ST SHELBYVILLE, IN 46176			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREF	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Based on observation	on and interview, the facility	K 0321	What corrective action	• •	DATE 11/08/2024
	failed to ensure 5 of such as storage room properly working so deficient practice of Findings include: Based on observation tour of the facility working self-close and latch door frames, each working self-close and latch door frames, each working such as paper construction materia. a) Resident Room self-closing device, storage. b) Resident Room store long construct door from closing. c) RR # 10B being equipped with a self-close and latch d) RR # 9B being with a self-closing of latch positively into	cover 10 hazardous area doors, ms, were provided with eff-closing devices. This build affect more than 6 staff. ons and interviews during a with the Maintenance Director between 11:30 a.m. and 2:45 corridor doors failed to positively into their respective were areas greater than 50 mg a mixture of combustible replastic, cardboard boxes, als, chairs and furniture: n #57, equipped with a the room is being used for m #46, the room is being used for an #46, the room is being used to ion pieces which prevent the gused for storage and f-closing device, did not positively into the door frame. It was door frame. It was door frame. It was door frame.	K 0321	accomplished for thos found to have been af deficient practice? All occupants had the be affected, none were hazardous material do been maintained with devices. These rooms 57, 46,10B, 9B and the How other residents h potential to be affected same deficient practic identified and what co action(s) will be taken. While all occupants ha potential to be affected All hazardous material been maintained with devices. All rooms we and none other were in What measures will be place and what system will be made to ensure deficient practice does	potential to e. All pors have self-closing include RR e kitchen. aving the d by the e will be rrective ? ave the d none were. I doors have self-closing re reviewed dentified.	11/08/2024
	equipped with a self	oor into the dining room f-closing device failed to The Kitchen contained eceptacles.		Maintenance director educated on hazardou doors and deficient pro	us room	

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

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

Page 9 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155022	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	x3) date survey COMPLETED 10/21/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2309 S MILLER ST SHELBYVILLE, IN 46176			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	again at the exit cor	or at the time of discovery and afference with the and Representative and the		facility tour completed, and no other areas identified. How the corrective action(s) wi monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor of designee will monitor all hazardous room doors weekly weeks then monthly thereafter months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	x4 x6 e t f	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities					
	failed to provide an returning cooking a when the kitchen he was designed and in extinguishing syste Ventilation Control Commercial Cookin Edition Section 12.	approved method for ppliances to where they were pod extinguishing equipment astalled for 1 of 1 kitchen hood m. NFPA 96 Standard for and Fire Protection of the Operations Section 2011 1.2.2* Cooking appliances a shall not be moved, modified,	K 0324	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice? All occupants had the potential be affected, none were. How other residents having the potential to be affected by the	to	

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

Event ID:

HEE021 Facility ID: 000009

If continuation sheet Page 10 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE.			ETED	
		155022	B. W	'ING		10/21/	2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
14/11 1 (0)4/	0.05.01151.004/111	_			MILLER ST		
VVILLOVV	S OF SHELBYVILL	.E		SHELB	YVILLE, IN 46176		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	or rearranged without prior re-evaluation of the				same deficient practice will be	;	
	_	ystem by the system installer			identified and what corrective		
		unless otherwise allowed by			action(s) will be taken?		
		e extinguishing system.			(-,		
		e fire-extinguishing system			While all occupants have the		
		evaluation where the cooking			potential to be affected none		
	-	ed for the purposes of			were.		
		eaning, provided the					
		ned to approved design					
		oking operations, and any			What measures will be put into	0	
	-	xtinguishing system nozzles			place and what systemic char		
		iances are reconnected in			will be made to ensure the	igoo	
	accordance with the manufacturer's listed design				deficient practice does not rec	ur?	
	manual. Section 12.1.2.3.1 An approved method				denoient praduce ades not rec	idi :	
		at will ensure that the			Maintenance director and diet	arv	
	-	d to an approved design			manager was educated on	ai y	
		ient practice affected 6, staff,			returning appliances back to t	hoir	
	and no residents.	ient practice affected 0, staff,			original location. Maintenance		
	and no residents.				director placed tape on the flo		
	The findings includ	۵۰			identify appliance location	OI to	
	The findings merad	C.			following hood cleaning.		
	Based on observation	ons and interviews during a			l lollowing flood cleaning.		
		with the Maintenance Director			How the corrective action(s) w	ill bo	
	-	petween 11:30 a.m. and 2:45			monitored to ensure that the	ill De	
	` /	rheeled two (6) burner range				-	
	*	was located on the cooking			deficient practice will not recui		
	_	in the kitchen was not			I.e., what Quality Assurance	2	
		oproved method that would			program will be put into place	f	
	-	-			The maniphage and accompanies as		
		iance was returned to an cation after it had been moved			The maintenance supervisor of		
					designee will monitor location		
		d cleaning. Based on interview			hood extinguishing equipment		
		ce Director, the facility was			weekly x4 weeks then monthly		
		ved method should be			months. The Quality Assurance		
	provided to ensure that the appliance was				and Performance Improvemen		
		oved design location after			committee will review results of		
	maintenance or clea				the findings during the monthl		
	This finding was ac				facility QA meeting for at least		
		for at the time of discovery and			months. At the end of the 6-m		
	again at the exit cor				period the QA team may opt to		
	Administrator, Regi	Administrator, Reginal Representative and the			discontinue the review of data		

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

Event ID:

HEE021 Facility ID: 000009

If continuation sheet Page 11 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155022		r í	UILDING	01	COMPL 10/21/	ETED	
	ROVIDER OR SUPPLIER S OF SHELBYVILL			2309 S	ADDRESS, CITY, STATE, ZIP COD MILLER ST YVILLE, IN 46176		
(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)	ΓE	(X5) COMPLETION DATE
	Maintenance Direct	or present.			during the meeting if complian is evident	ce	
	failed to install the laccordance with the Section 9.2.3 states equipment shall be in NFPA 96, Standard Fire Protection of COperations. NFPA states kitchen range equipped with a dripedges. The tray shall needed to collect gridrain into an enclos capacity not exceed deficient practice confirmed from the facility with the compact of the facility with two dripedges. The tray shall needed to collect gridrain into an enclos capacity not exceed deficient practice confirmed from the facility with the facility with the design of the drange hood system, the location of the drange hood system, the location of the drange hood system. This finding was act Maintenance Direct again at the exit confirmed from the drange hood system.	knowledged by the or at the time of discovery and afterence with the and Representative and the					
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System	- Installation					

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

Event ID:

HEE021 Facility ID: 000009

If continuation sheet Page 12 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155022		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 2 01	(X3) DATE SURVEY COMPLETED 10/21/2024		
NAME OF PROVIDER OR SUPPLIER WILLOWS OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 2309 S MILLER ST SHELBYVILLE, IN 46176			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
iAu	Based on observation failed to maintain the accordance with NI Installation of Spring edition, Section 6.2 or other devices use around a sprinkler solisted for use around practice could affect Findings include: Based on observation of the facility of th	on and interview, the facility the ceiling construction in in FPA 13, Standard for the mkler Systems. NFPA 13, 2010 1.7.1 states plates, escutcheons, and to cover the annular space shall be metallic or shall be d a sprinkler. This deficient at 2 staff. ons and interviews during a with the Maintenance Director between 11:30 a.m. and 2:45 ler Heads in the HR Storage ag into the room approximately d a gap around the sprinkler ased on interviews at the time Maintenance Director agreed area would need to be eknowledged by the tor at the time of discovery and inference with the inal Representative and the	K 0351	What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice? 2 staff had the potential to be affected, none were. The sprint head and ceiling construction in the HR closet was repaired. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? While all occupants have the potential to be affected none were the sprinkler head and ceiling construction in HR closet was repaired. What measures will be put into place and what systemic chang will be made to ensure the deficient practice does not recult Maintenance director was educated on installation of sprinkler systems and ceiling construction. A facility tour was completed, and no other areas were identified. How the corrective action(s) will monitored to ensure that the deficient practice will not recur.	ts the 11/08/2024 ts the line line line line line line line lin	

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

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

program will be put into place?

Page 13 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155022	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/21/2024
	ROVIDER OR SUPPLIER S OF SHELBYVILL		2309 S	ADDRESS, CITY, STATE, ZIP COD 6 MILLER ST BYVILLE, IN 46176	
(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 0363 SS=E Bldg. 01	failed to ensure 3 of impediment to closi frame and would re This deficient pract. Findings include: Based on observation tour of the facility of (MD) on 10/21/24 to p.m., the following positively into their would not resist the a) The Laundry Seast hall had a self-Maintenance Direct	on and interview, the facility fover 50 corridor doors had no ng and latching into the door sist the passage of smoke. ice could affect 8 staff. ons and interviews during a with the Maintenance Director between 11:30 a.m. and 2:45 corridor doors failed to latch respective door frames or passage of smoke: storage corridor door on the closing device which the or stated was not "hooked led to self-close and latch.	K 0363	The maintenance supervisor of designee will monitor sprinkle system and ceiling construction weekly x4 weeks and then monthly x6 months. The Quarks assurance and Performance Improvement committee will results of the findings during the monthly facility QA meeting for least 6 months. At the end of 6-month period the QA team of the opt to discontinue the review of data during the meeting if compliance is evident. K363 What corrective action(s) will accomplished for those reside found to have been affected by deficient practice? All occupants had the potentiation be affected, none were. The identified doors have been maintained and now close and latch into door frame. Holes he been repaired in the maintenation door. These rooms include the laundry room, maintenance roand medical supply room. How other residents having the potential to be affected by the	r on lity eview the grat the may of the ents by the latto 3 disave since the poom the little on the

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

Event ID:

HEE021 Facility ID: 000009

If continuation sheet Page 14 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155022	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2024			
	PROVIDER OR SUPPLIER /S OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 2309 S MILLER ST SHELBYVILLE, IN 46176				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDE PREFIX (EACH CORRECTED CROSS-REFERE TAG	RIS PLAN OF CORRECTION CTIVE ACTION SHOULD BE NICED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
	b The Maintenance Room corridor door on station 1 east hall had a hole in the door which penetrated completely through. The MD agreed that the door would not resist the passage of smoke. c) The Medical Supply Corridor door equipped with a self-closing device failed to self-close and	identified an action(s) wil While all occupotential to be	ent practice will be id what corrective I be taken? cupants have the be affected none were. Ir was completed and			
	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present.	What measi place and w will be made	were identified. ures will be put into hat systemic changes e to ensure the actice does not recur?			
	3.1-19(b)	educated or impediments and/or holes facility tour other areas	e director was n doors having no s of closing, latching, s in door or frame. Full completed, and no identified. rective action(s) will be o ensure that the			
		deficient pra	netice will not recur. uality Assurance be put into place?			
		designee wi weekly x4 w thereafter x6 Assurance a Improvemer results of th monthly faci least 6 mont 6-month per	nance supervisor or Il monitor all corridors reeks then monthly 6 months. The Quality and Performance nt committee will review e findings during the lity QA meeting for at ths. At the end of the riod the QA team may ntinue the review of			
		I -	the meeting if			

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

Event ID:

HEE021 Facility ID: 000009

If continuation sheet Page 15 of 20

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155022	A. BUILDING B. WING	01	COMPLETED 10/21/2024		
NAME OF PROVIDER OR SUPPLIER WILLOWS OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 2309 S MILLER ST SHELBYVILLE, IN 46176				
(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		
				compliance is evident ="" p="">			
				="" p=""> ="" p=""> ="" p=""> ="" a the="" maintenance="" director="" added="" new="" parts,="" replaced="" worn="" parts="" and="" or="" made=" adjustments="" to="" closing= latching="" mechanism="" ensure="" proper="" of="" doors="" that="" identified.<=" p=""> ="" p="">	m		
				="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" span="">			

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

Event ID:

HEE021

Facility ID: 000009

If continuation sheet

Page 16 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155022		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/21/2024	
	ROVIDER OR SUPPLIER S OF SHELBYVILL		2309 S	ADDRESS, CITY, STATE, ZIP COD MILLER ST BYVILLE, IN 46176	
(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=E Bldg. 01	failed to ensure 5 of used as a portion of heating, ventilating, ductwork serving ac requires air condition ductwork and relate accordance with NF Installation of Air C Systems. NFPA 90 4.3.12.1.1 states egras a portion of a sur system serving adjopermitted by 4.3.12 deficient practice constaff and visitors. Findings include: Based on observation tour of the facility work (MD) on 10/21/24 bp.m., all rooms in S	on and interview, the facility 14 egress corridors were not 2 return air system/plenum for 3 or air conditioning (HVAC) 3 djoining areas. LSC 19.5.2.1 3 oning, heating, ventilating 3 d equipment to be installed in 3 PA 90A, Standard for the 3 conditioning and Ventilating 4 A, 2012 Edition, Section 3 ress corridors shall not be used 3 oply, return, or exhaust air 3 ining areas unless otherwise 3 1.3.1 through 4.3.12.1.3.4. This 3 ould affect over 30 residents, 3 ons and interviews during a 4 with the Maintenance Director 5 oetween 11:30 a.m. and 2:45 5 tation 1 (west wing), Station 2 6) and Station 3 were using the	K 0521	="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> =" span=""> ="" span="" span	in ling. stem wn ons oe om
	(cast and west willg	, and station s were using the			

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

Event ID:

HEE021 Facility ID: 000009

Page 17 of 20 If continuation sheet

11/08/2024 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						MB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155022		A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/21/2024		
NAME OF PROVIDER OR SUPPLIER WILLOWS OF SHELBYVILLE				2309 S	ADDRESS, CITY, STATE, ZIP COD MILLER ST SYVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	interview at the tim Maintenance Direct past had a waiver fit corridor as a portion system and agreed a corridors were being. This finding was at Maintenance Direct again at the exit con Administrator, Reg Maintenance Direct 3.1-19(b) NFPA 101 Electrical Equipment Extens 1. Based on observation of the same and equipment shall 70, National Electrical Edition, Article 400 specifically permitt shall not be used as a structure. This deresident. Findings include: Based on observation of the facility of the	for at the time of discovery and inference with the inal Representative and the	K 0	920	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice? 2 residents and the kitchen state had the potential to be affected none were. The muti plug adain room 100 was removed and extension cord in the kitchen weremoved. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? While all residents have the potential to be affected none	nts / the ff I, pter the //as	11/08/2024

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

agreed a mulita-plug adaptor was in use in room

Event ID:

HEE021

Facility ID: 000009

were. The muti plug adapter in

If continuation sheet

Page 18 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	LETED
155022		B. WING 10/21/2024			/2024		
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					MILLER ST		
WILLOWS OF SHELBYVILLE					YVILLE, IN 46176		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	100.				room 100 was removed and the		
	_	cknowledged by the			extension cord in the kitchen v		
		tor at the time of discovery and			removed. Facility tour complet		
	again at the exit con				to ensure no power strips wer		
		inal Representative and the			used in patient care vicinity ar	nd no	
	Maintenance Direc	tor present.			extension cords being used.		
	2. Based on observ	ation and interview, the facility			What measures will be put into	0	
	failed to ensure 1 o	f 1 flexible cords in the kitchen			place and what systemic char	iges	
	were not used as a	substitute for fixed wiring.			will be made to ensure the		
	NFPA-70/2011, 40	0.8 state unless specifically			deficient practice does not rec	:ur?	
	permitted in 400.7 flexible cords and cables shall						
	not be used for (1)	as a substitute for fixed wiring.			Maintenance Director and all	staff	
	This deficient pract	tice could affect up to 6 staff in			were educated on use multiple	ug	
	the kitchen.				adapters and extension cords	in	
					facility. Facility tour completed	d to	
	Findings include:				ensure no power strips were ι	ısed	
					in patient care vicinity and no		
	Based on observation	ons and interviews during a			extension cords being used.		
	tour of the facility	with the Maintenance Director					
	(MD) on 10/21/24	between 11:30 a.m. and 2:45			How the corrective action(s) w	/ill be	
	_	an orange extension cord was			monitored to ensure that the		
	plugged in and pow	vering a grease fryer which was			deficient practice will not recu	r.	
		. Based on interview at the			I.e., what Quality Assurance		
		, the MD acknowledged an			program will be put into place	?	
		in use as described above and					
	was unsure how long this had been occurring. This finding was acknowledged by the				The maintenance supervisor of	or	
					designee will monitor all areas		
		tor at the time of discovery and			the building in relation to elect	rical	
	again at the exit con				equipment weekly x4 weeks tl		
	_	inal Representative and the			monthly x 6 months. The Qua	ality	
	Maintenance Direc	tor present.			Assurance and Performance		
					Improvement committee will re		
	3.1-19(b)				results of the findings during t	he	
					monthly facility QA meeting fo		
					least 6 months. At the end of t		
					6 month period the QA team r	nay	
					opt to discontinue the review of	of	
					data during the meeting if		
		1		compliance is evident		İ	

Pl

PRINTED: 11/08/2024

FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155022	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/21/2024	
NAME OF PROVIDER OR SUPPLIER WILLOWS OF SHELBYVILLE			2309 S	ADDRESS, CITY, STATE, ZIP COD MILLER ST YVILLE, IN 46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY 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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HEE021 Facility ID: 000009 If continuation sheet Page 20 of 20