Lindsey

PRINTED: 06/12/2023 FORM APPROVED OMB NO. 0938-039

05/31/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIES		36 VAL	STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0000						
Bldg. 00	IN00407790 and I		F 0000			
	the allegations are	7790 - No deficiencies related to cited.				
	-	6692 - Federal/State deficiencies ations are cited at F755.				
	Survey dates: May	10 and 11, 2023				
	Facility number: 00 Provider number: 1 AIM number: 1002	55525				
	Census Bed Type: SNF/NF: 78 Total: 78					
	Census Payor Type Medicare: 2 Medicaid: 58 Other: 18	::				
	Total: 78					
	This deficiency ref accordance with 41	lects State Finding cited in 0 IAC 16.2-3.1.				
	Quality review con	npleted on May 15, 2023.				
F 0755 SS=E Bldg. 00	§483.45 Pharmad The facility must pemergency drugs	s/Pharmacist/Records				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE	

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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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Boltz

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	described in §483 permit unlicensed drugs if State law general supervision §483.45(a) Proceed provide pharmaced procedures that are acquiring, receiving administering of a meet the needs of the second pharmaced pharm	personnel to administer permits, but only under the on of a licensed nurse. dures. A facility must sutical services (including saure the accurate og, dispensing, and of each resident. The Consultation. The facility of the services of a sist who- vides consultation on all vision of pharmacy services ablishes a system of and disposition of all or sufficient detail to enable ciliation; and ermines that drug records that an account of all is maintained and ciled. and record review, the facility medications in a timely manner reviewed for medications.	F 0755	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegation. We reserve the right to contain the findings or allegations a part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility	06/09/2023 ng ons. est	
I	I ochavior or oralli, li	ypercusion, and dipolal	1	requests that the plan of	ı	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155525		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/11/2023			
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	TION (X5) ILD BE COMPLETION ROPRIATE DATE		
	REGULATORY OF disorder. A Medication Adm physician ordered reprovided by the DC 5/11/23 at 12:00 per resident's medication following dates and were given at 9 - On 4/6/23 the meand were given at 9 - On 4/9/23 the meand were given at 1 - On 4/10/23 the meand were given at 1 - On 4/11/23 the meand were given at 1 - On 4/12/23 the meand were given at 1 - On 4/12/23 the meand were given at 1 - On 4/12/23 the meand were given at 1 - On 4/12/23 the meand were given at 1 - On 4/13/23 the meand were given at 1 - On 4/13/23 the meand were given at 9 - On 4/16/23 the meand were given at 9 - On 4/16/23 the meand were given at 1 - On 4/17/23 the meand were given at 1 - On 4/17/23 the meand were given at 1 - On 4/17/23 the meand were given at 9 - On 4/18/23 the meand were given at 9 - On 4/19/23 the	inistration Audit Report for the nedications for Resident B was DN (Director of Nursing) on m. The report indicated the ons were given late on the I times: dications were due at 7:00 p.m. 2:10 p.m., dications were due at 7:00 p.m. 2:15 p.m., dications were due at 7:00 p.m. 4:10/23 at 12:03 a.m., dications were due at 7:00 a.m. 2:00 a.m., edications were due at 7:00 p.m. 1:39 p.m., edications were due at 7:00 p.m. 1:21 p.m., edications were due at 7:00 p.m. 1:44 p.m., edications were due at 7:00 a.m. 0:40 a.m., edications were due at 7:00 a.m. 0:42 p.m., edications were due at 7:00 a.m. 0:33 a.m., edications were due at 7:00 a.m. 0:15 a.m., edications were due at 7:00 a.m. 0:15 a.m., edications were due at 7:00 a.m. 0:21 a.m., edications were due at 7:00 a.m.		correction be considered allegation of compliance effective 6-9-23 for the Complaint Investigation completed on May 10 at 2023. We respectfully repaper review and will proper review and will proper review and will proper review and service conducted in a manner in accordance with deprof health and human secenters for Medicare and Medicaid services. The Corrective Action taken those residents found to affected by the deficient practice include: It is the of this facility to ensure residents are administed medications in a timely manner. Residents, B, C and F have not experient negative outcomes because the alleged deficient practice include. The properties of the alleged deficient practice includes the alleged deficie	ed our e Ind 11, equest a rovide con If this I s are that are artment rvices d I S P D D D D D D D D D D D D D D D D D D		
	I - On 4/21/23 the me	edications were due at 7:00 a.m.	1	medication have the po	tential		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/11/2023		
NAME OF F	PROVIDER OR SUPPLIER	•		ADDRESS, CITY, STATE, ZIP COD	-	
	NOOK CARE CENT		36 VALLEY DR LAWRENCEBURG, IN 47025			
	<u> </u>	STATEMENT OF DEFICIENCIE	ID		(V5)	
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION	
TAG	`	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
	and were given at 1			to be affected. All resident		
		edications were due at 7:00 a.m.		MARS were reviewed for lat	e	
	and were given at 1	0:14 a.m.,		administrations and MD		
	- On 4/24/23 the me	edications were due at 7:00 a.m.		notified of all identified.		
	and were given at 1	0:08 a.m.,		Please see below for		
	- On 4/25/23 the me	edications were due at 7:00 a.m.		measures implemented to		
	and were given at 1			prevent reoccurrence.The		
		edications were due at 7:00 a.m.		measures or systemic chan	ges	
	and were given at 1			that have been put into plac	<u>e</u>	
		edications were due at 7:00 a.m.		to ensure that the deficient		
	and were given at 9			practice does not recur		
	- On 4/28/23 the medications were due at 7:00 a.m.			include: All nursing was		
	and were given at 10:14 a.m.,			in-serviced by the Director of		
	- On 4/29/23 the medications were due at 7:00 a.m.			Nursing/ designee on the poli	icies	
	and were given at 1			entitled "Medication		
		edications were due at 7:00 a.m.		Administration" related to		
	and were given at 1			administering medication time	ely or	
		edications were due at 7:00 p.m.		informing the MD when not		
	and were given at 1	-		administered timely with		
		dications were due at 7:00 a.m.		appropriate documentation. A		
	and were given at 8			well as ensuring medication of		
		lications were due at 7:00 p.m.		are assigned to correct times	per	
	and were given at 1	-		hall. In-service has been		
	and were given at 8	dications were due at 7:00 a.m.		conducted with the IDT team	ation	
		lications were due at 7:00 p.m.		related medication administra		
	and were given at 8	_		policy. Medication administra will be reviewed as part of the		
	_	lications were due at 7:00 a.m.				
	and were given at 1			clinical morning meeting to en that medications are being	iouic	
	_	lications were due at 7:00 a.m.		administered in a timely man	ner	
	and were given at 9			according to policy or that the		
	_	lications were due at 7:00 a.m.		medical provider if aware of a		
	and were given at 9			late administrations. The	··· <i>y</i>	
	_	lications were due at 7:00 p.m.		corrective action taken to		
	and were given at 9	_		monitor performance to ass	ure	
		lications were due at 7:00 a.m.		compliance through quality		
	and were given at 1			assurance is: A performance		
	_	lications were due at 7:00 p.m.		improvement tool has been		
		5/7/23 at 12:09 a.m.,		initiated that observes medica	ation	
	_	lications were due at 7:00 p.m.		administration times and that		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	COMPLETED	
		155525	B. W	B. WING 05/11/2		
				CTREET	ADDRESS SITE STATE SID COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD	
OLIA DV	NOOK OADE OENT				LEY DR	
SHADY	NOOK CARE CENT	ER		LAWRE	ENCEBURG, IN 47025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENCE N. AN 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 DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DATE	
	and were given at 10:51 p.m.,				are correlated with the assigne	ed
	_	dications were due at 7:00 a.m.			hall medication pass times. In	
	and were given at 1				addition to the daily audits a	
	_	dications were due at 7:00 a.m.			monitoring for a minimum of	
	and were given at 1				weeks or until substantial	
	_	edications were due at 7:00 a.m.			compliance is achieved, a	
	and were given at 9				Quality Assurance tool has	
	and word green are				been developed and	
	2. The record for Re	esident C was reviewed on			implemented to monitor that	
		m. The diagnoses included, but			medication times are accurate	
	were not limited to, heart failure, kidney failure,				according to hall. This tool v	
	and anxiety.				be completed by the DON, or	
	and anxiety.				designee, weekly x3 weeks,	
	A Medication Administration Audit Report for the				monthly for 3 months, then	
	physician ordered medications for Resident C was				quarterly for 2 quarters. Any	
		ON on 5/11/23 at 12:00 p.m. The			identified issues will be	
		resident's medications were			immediately addressed. The	
	_	llowing dates and times:			outcomes will be reviewed	
	given rate on the ro	nowing dates and times.			through the facility Quality	
	- On 4/1/23 the med	dications were due at 9:00 p.m.			Assurance Program. Monitor	ina
	and were given at 1	_			will continue as planned or w	_
	_	dications were due at 9:00 p.m.			be increased by the Quality	,,,,
	and were given at 1	_			Assurance Committee if	
	_	dications were due at 9:00 p.m.			needed to obtain 100%	
	and were given at 5	-			compliance. Additional actio	n
	_	dications were due at 9:00 a.m.			will be taken by the Quality	.
		2:30 p.m. and 1:18 p.m.,			Assurance Committee if	
	_	dications were due at 9:00 p.m.			warranted based on the	
		4/7/23 at 12:01 a.m.,			outcome of tools. The date th	_
	_	dications were due at 9:00 a.m.			systemic changes will be	<u> </u>
	and were given at 1				completed: 6-09-23	
	_	edications were due at 9:00 a.m.			Sompietoa.	
	and were given at 1					
	_	edications were due at 9:00 p.m.				
	and were given at 1	•				
	_	edications were due at 9:00 a.m.				
	and were given at 1					
	_	edications were due at 9:00 p.m.				
	and were given at 1	_				
	_	-				
	- On 4/13/23 the me	edications were due at 9:00 p.m.				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR				
SHADY	NOOK CARE CENT	ER	LAWRE	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 CROSS-REFERENCED TO THE APPRO	BE COMPLETI	ON	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	_	4/14/23 at 3:16 a.m.,					
		edications were due at 9:00 p.m.					
	and were given at 1	-					
		edications were due at 9:00 p.m.					
	and were given at 1	-					
		edications were due at 9:00 a.m.					
	and were given at 1	1:23 a.m., edications were due at 9:00 p.m.					
	and were given at 1	-					
	_	edications were due at 9:00 a.m.					
	and were given at 1						
	_	edications were due at 9:00 p.m.					
	and were given at 1	_					
		edications were due at 9:00 a.m.					
	and were given at 1	1:04 a.m.,					
	- On 4/26/23 the me	edications were due at 9:00 a.m.					
	and were given at 1	2:01 p.m.,					
	- On 4/26/23 the me	edications were due at 9:00 p.m.					
	and were given at 1	-					
		edications were due at 9:00 a.m.					
	and were given at 1						
		edications were due at 9:00 a.m.					
	_	0:40 a.m. and 3:15 p.m., and					
		edications were due at 9:00 a.m.					
	and were given at 1	1:14 a.m.					
	3 During an intervi	ew on 5/10/23 at 2:23 p.m.,					
	_	ed she frequently received her					
	medications up to to						
	The record for Resi	dent D was reviewed on					
	5/10/23 at 3:01 p.m	. The diagnoses included, but					
		hemiplegia following					
	intracranial hemorr						
		symbolic dysfunctions, and					
		e. The resident's cognition was					
	moderately impaire	d.					
		inistration Audit Report for the					
	pnysician ordered n	nedications for Resident D was					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		A. BUILDING 00 B. WING			COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER			36 VALL	DDRESS, CITY, STATE, ZIP COD LEY DR NCEBURG, IN 47025		
OHABIT	TOOK OF IKE OPIN				110280110, 111 17 020		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG			+	TAG	BEITEERETT		DATE
	1 -	ON on 5/11/23 at 12:00 p.m. The					
		resident's medications were					
	given late on the fol	llowing dates and times:					
	- On 4/3/23 the med and were given at 7	lications were due at 7:00 a.m. :59 p.m.,					
	- On 4/3/23 the med	dications were due at 7:00 p.m.					
	and were given at 1	0:28 p.m.,					
	- On 4/5/23 the med	dications were due at 7:00 p.m.					
	and were given at 9	:17 p.m.,					
		dications were due at 7:00 p.m.					
	and were given at 9:06 p.m.,						
	- On 4/8/23 the medications were due at 7:00 a.m.						
	and were given at 3:39 p.m.,						
		dications were due at 7:00 a.m.					
	and were given at 5	-					
		dications were due at 7:00 p.m.					
	_	4/10/23 at 6:00 a.m.,					
		edications were due at 7:00 a.m.					
	and were given at 1						
		edications were due at 7:00 p.m.					
	and were given at 1	-					
		edications were due at 7:00 p.m.					
	_	4/13/23 at 5:45 a.m., edications were due at 7:00 a.m.					
	and were given at 4						
	_	edications were due at 7:00 p.m.					
	and were given at 1	-					
		edications were due at 7:00 p.m.					
	and were given at 1	_					
	_	edications were due at 7:00 a.m.					
	and were given at 9						
	_	edications were due at 7:00 p.m.					
	and were given at 9	_					
	_	edications were due at 7:00 p.m.					
	and were given at 1	1:57 p.m.,					
	- On 4/21/23 the me	edications were due at 7:00 p.m.					
	and were given at 9						
	- On 4/23/23 the me	edications were due at 7:00 p.m.					
	and were given at 9	:16 p.m.,					

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	BE COMPLETION		
	(EACH DEFICIEN REGULATORY OR - On 4/24/23 the mean and were given at 1 - On 4/27/23 the mean and were given at 1 - On 4/27/23 the mean and were given at 9 - On 4/30/23 the mean and were given at 9 - On 4/30/23 the mean and were given at 9 - On 4/30/23 the mean and were given at 9 - On 4/30/23 the mean and were given at 9 - On 4/30/23 the mean and were given at 1 - On 4/2/23 the mean and were given at 1 - On 4/2/23 the mean and were given at 1 - On 4/3/23 the mean and were given at 1 - On 4/3/23 the mean and were given on 4 - On 4/4/23 the mean and were given at 1 - On 4/5/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 1 - On 4/6/23 the mean and were given at 5	CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION edications were due at 7:00 p.m. :16 p.m., edications were due at 7:00 p.m. 0:30 p.m., edications were due at 7:00 p.m. 0:54 a.m. and 5:14 p.m., edications were due at 7:00 p.m. :03 p.m., and edications were due at 7:00 p.m. :25 p.m. esident E was reviewed on . The diagnoses included, but chronic obstructive pulmonary abetes mellitus, heart failure, inistration Audit Report for the nedications for Resident E was en on 5/11/23 at 3:11 p.m. The resident's medications were flowing dates and times: flications were due at 7:00 p.m. 1:21 p.m., flications were due at 9:00 p.m. 4/4/23 at 12:13 a.m., flications were due at 9:00 p.m.		(EACH CORRECTIVE ACTION SHOULD B	BE COMPLETION		
	and were given at 1 - On 4/12/23 the me	0:56 p.m., edications were due at 6:00 a.m.					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		1	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE	
1110	and were given at 1						5.112	
	_	edications were due at 9:00 a.m.						
	and were given at 1							
	_	edications were due at 9:00 p.m.						
	and were given at 1	_						
	_	edications were due at 9:00 p.m.						
	and were given at 1	_						
	_	edications were due at 6:00 a.m.						
	and were given at 5	:18 p.m.,						
	_	edications were due at 6:00 a.m.						
	and were given at 7	:54 a.m.,						
	- On 4/20/23 the me	edications were due at 9:00 a.m.						
	and were given at 1	1:04 a.m.,						
	- On 4/23/23 the me	edications were due at 9:00 a.m.						
	and were given at 1	1:10 a.m.,						
	- On 4/25/23 the me	edications were due at 9:00 p.m.						
	and were given on	4/26/23 at 12:06 a.m.,						
	- On 4/26/23 the me	edications were due at 9:00 a.m.						
	and were given at 1	0:59 a.m.,						
	- On 4/28/23 the me	edications were due at 9:00 a.m.						
	and were given at 1	2:11 p.m., and						
	- On 4/28/23 the me	edications were due at 9:00 p.m.						
	and were given at 1	1:15 p.m.						
	5. The record for Ro	esident F was reviewed on						
	5/11/23 at 2:47 p.m	. The diagnoses included, but						
	were not limited to,	acute and chronic respiratory						
	failure with hypoxia	a, hyperlipidemia,						
	encephalopathy, and	d cardiac defibrillator.						
	A Medication Adm	inistration Audit Report for the						
	physician ordered n	nedications for Resident F was						
	* *	ON on 5/11/23 at 3:11 p.m. The						
	report indicated the	resident's medications were						
	_	llowing dates and times:						
	- On 4/1/23 the med	dications were due at 8:00 p.m.						
	and 9:00 p.m. and v	vere given at 11:36 p.m.,						
	_	dications were due at 2:00 p.m.						
	and were given at 4	:21 p.m.,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 05/11/	ETED	
	PROVIDER OR SUPPLIER		3	6 VALL	DDRESS, CITY, STATE, ZIP COD EY DR NCEBURG, IN 47025		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	REGULATORY OR - On 4/3/23 the med and 9:00 p.m. and v a.m., - On 4/6/23 the med and 9:00 p.m. and v - On 4/10/23 the med and 9:00 p.m. and v - On 4/11/23 the med and 9:00 p.m. and v - On 4/13/23 the med and 9:00 p.m. and v - On 4/13/23 the med and 9:00 p.m. and v - On 4/13/23 the med and 9:00 p.m. and v - On 4/13/23 the med and 9:00 p.m. and v - On 4/13/23 the med and 9:00 p.m. and v - On 4/15/23 the med and 9:00 p.m. and v - On 4/16/23 the med and 9:00 p.m. and v - On 4/16/23 the med and 9:00 p.m. and v - On 4/16/23 the med and 9:00 p.m. and v - On 4/16/23 the med and 9:00 p.m. and v - On 4/20/23 the med and 9:00 p.m. and v - On 4/20/23 the med and 9:00 p.m. and v - On 4/20/23 the med and 9:00 p.m. and v - On 4/21/23 the med and 9:00 p.m. and v - On 4/21/23 the med and 9:00 p.m. and v - On 4/21/23 the med and 9:00 p.m. and v - On 4/21/23 the med and 9:00 p.m. and v - On 4/21/23 the med and 9:00 p.m. and v - On 4/25/23 the med and 9:00 p.m. and v - On 4/25/23 the med and 9:00 p.m. and v - On 4/25/23 the med and 9:00 p.m. and v - On 4/25/23 the med and 9:00 p.m. and v - On 4/25/23 the med and were given at 5	dications were due at 8:00 p.m. were given at 11:36 p.m., dications were due at 8:00 p.m. were given on 4/5/23 at 4:35 dications were due at 6:00 a.m. dications were due at 8:00 p.m. were given at 11:37 p.m., dications were due at 8:00 p.m. were given at 11:19 p.m., dications were due at 8:00 p.m. were given at 10:41 p.m., dications were due at 8:00 p.m. were given at 10:41 p.m., dications were due at 8:00 p.m. were given at 10:32 p.m., dications were due at 8:00 p.m. were given at 10:32 p.m., dications were due at 8:00 p.m. were given at 10:32 p.m., dications were due at 8:00 p.m. were given at 10:44 p.m., dications were due at 8:00 p.m. were given at 10:44 p.m., dications were due at 8:00 p.m. were given at 10:44 p.m., dications were due at 8:00 p.m. were given at 10:44 p.m., dications were due at 8:00 p.m. were given at 10:44 p.m., dications were due at 8:00 p.m. were given at 10:44 p.m., dications were due at 8:00 p.m. were given at 10:44 p.m., dications were due at 8:00 p.m. were given at 11:13 p.m., dications were due at 8:00 p.m. were given at 11:13 p.m., dications were due at 8:00 p.m. were given at 11:13 p.m., dications were due at 8:00 p.m. were given at 11:22 p.m., dications were due at 8:00 p.m. were given at 11:22 p.m., dications were due at 2:00 p.m. were given at 11:22 p.m., dications were due at 2:00 p.m.		AG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE
	311 1/23/23 the like	alleanons were due ut 0.00 p.m.	1				

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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 00	(X3) DATE SURVEY COMPLETED 05/11/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION		
	a.m., On 4/26/23 the me p.m. and were giver On 4/27/23 the me 9:00 p.m., and 10:0 4/28/23 at 3:09 a.m On 4/28/23 the me and 9:00 p.m. and v a.m., On 4/30/23 the me and were given at 3 On 4/30/23 the me and 9:00 p.m. and v During an interview Qualified Medication when medications v document the actual given. The medication before and one hour administration time During an interview indicated when medications was given computer document medications was given one hour beformedications were d During a confidentification, a resident received he times and days. During an interview DON indicated medicated medicat	edications were due at 8:00 p.m. evere given on 4/29/23 at 12:11 edications were due at 2:00 p.m. evere given at 10:49 p.m. evere given at 10:49 p.m. evere given at 10:29 a.m., on Aide (QMA) 2 indicated evere given, the staff were to a time the medication was cons could be given one hour evere after the scheduled evere given the even. The medications could be even and one hour after the even. The medications could be even and one hour after the even. The medications could be even and one hour after the even. The medications could be even even even even the even even the even even the even even the even the even the even the even even the even even the even th					

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

PRINTED: 06/12/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525 NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				ETED	
(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
1110	The current facility Medications" with a 2012 was provided policy indicated, ". administered in a sa prescribed3. Med within one (1) hour	policy titled, " Administering a revised date of December by the Administrator. TheMedications shall be fe and timely manner, and as ications must be administered of their prescribed time"		1110			DATE

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