Lindsey Boltz

continued program participation.

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

11/02/2023

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/11/2023	
	PROVIDER OR SUPPLIED		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	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 10/1 Facility Number: (Provider Number: AIM Number: 100 At this Life Safety Center was found in Preparedness Required Medicaid Participation CFR 483.73.	1/23  000304 155525 1266810  Code survey, Shady Nook Care in compliance with Emergency irements for Medicare and ting Providers and Suppliers, 42  certified beds. At the time of	E 0000			
K 0000	Quality Review con	mpleted on 10/16/23				
K 0000						
Bldg. 01	Licensure Survey v Department of Hea 483.90(a).  Survey Date: 10/1  Facility Number: ( Provider Number: AIM Number: 100  At this Life Safety	000304 155525	K 0000			
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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: K1NP21 Facility ID: 000304 If continuation sheet Page 1 of 43

Administrator

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/11/2023		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR  LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 0161 SS=E Bldg. 01	REGULATORY OR LSC IDENTIFYING INFORMATION Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.  This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 83 at the time of this survey.  All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.  Quality Review completed on 10/16/23  NFPA 101  Building Construction Type and Height Building Construction Type and Height 2012 EXISTING  Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7  19.1.6.4, 19.1.6.5  Construction Type  1 (442), I (332), II (222) Any number	TAG	DEFICIENCY			
	of stories non-sprinklered and sprinklered					
	2 II (111) One story non-sprinklered Maximum 3 stories					

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 2 of 43

PRINTED: 11/08/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155525	B. WING		10/11/2023	
NAME OF	DD OVADED OD GUDDU IEI		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF		36 VAI	LLEY DR		
SHADY	NOOK CARE CENT	TER	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 APPROPRIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	sprinklered					
	3 II (000)	Not allowed				
	non-sprinklered					
	4 III (211)	Maximum 2 stories				
	sprinklered					
	5 IV (2HH)					
	6 V (111)	,				
	7 III (200)	Not allowed				
	non-sprinklered	riot anomou				
	8 V (000)	Maximum 1 story				
	sprinklered	Waximam 1 Story				
		s must be sprinklered				
	1 '	approved, supervised				
	1 .	in accordance with section				
	9.7. (See 19.3.5)	in accordance with section				
		iption, in REMARKS, of the				
		number of stories, including				
		on which patients are				
	· ·	of smoke or fire barriers and				
		. Complete sketch or attach				
		the building as appropriate.				
		view, observation and	K 0161	By submitting the enclosed	10/12/2023	
		ity failed to maintain the	KOTOT	material, we are not admitting the	<b>I</b>	
		on type for Type V(111)		truth or accuracy of any specific		
	_	6 fire walls. This deficient		findings or allegations. We rese		
		et over 20 residents, staff and		the right to contest the findings	<b>I</b>	
	visitors.	over 20 residents, stair and		allegations as part of any		
				proceedings and submit these		
	Findings include:			responses pursuant to our		
	- mamas moraco.			regulatory obligations. The facili	itv	
	Based on review of	facility floor plan		requests that the plan of	'·'	
		the Administrator and the		correction be considered our		
		tor during record review from		allegation of compliance effective	/e	
		p.m. on 10/11/23, 2-hour fire		11-02-23 for the Emergency		
	1	e walls are located at the		Preparedness survey date		
		treet wing, the B Street wing,		10/11/23 and for the Life and		
	1		1	1 .5, 1 1,25 and for the Life and	1	

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

the C Street wing and the D Street wing by Room

41. Based on observations with the Administrator

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Safety recertification and state

licensure survey conducted on

Page 3 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155525	B. W	NG		10/11/2	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			LEY DR		
SHADY N	NOOK CARE CENT	FR			ENCEBURG, IN 47025		
011/1011				L/ WYI (L			
(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 APPROPRIATE	.TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ee Director during a tour of the			10/11/23. We respectfully requ		
	facility from 12:10 p.m. to 2:10 p.m. on 10/11/23, the entrance doors to the A Street wing by Room 11 were each equipped with a 90-minute fire resistance rating label affixed to the hinge side of door. Each door in the fire door set was equipped				a paper review and will provid	, ,	
					additional information request	ed.	
					<u>K161</u>		
	_	vare and each door latched into			It is the practice of this facility		
	the door frame when tested to close. Foam was				ensure the building construction	on is	
	used to firestop the attic fire barrier wall				maintained for Type V (111)		
		hite HVAC pipe which			construction for 6 of 6 fire wall		
	penetrated the attic fire barrier wall above the				The corrective action taken f	or	
		the A Street wing by Room 11.			those residents found to be		
	Based on interview				affected by the deficient		
		faintenance Director stated the			practice include:		
	UL listing and/or fi	——————————————————————————————————————			It is the policy of this facility to		
		the foam used to firestop the			ensure that the construction o	rtne	
	attic fire barrier wa	ll was not available for review.			facility is maintained to meet		
	Those findings wan	e reviewed with the			regulation, ensuring that		
	_	the Maintenance Director			appropriate firestop is utilized		
	during the exit conf				the attic fire barrier wall(s) and		
	during the exit com	terence.			documentation is present with required UL listing and/or fire	uie	
	3.1-19(b)				resistance rating. No resident	to or	
	3.1-17(0)				staff were affected by this	.5 01	
					requirement not met. Area of		
					concern to the wall above the		
					corridor door set to the A street	et	
					wing, by room 11, construction		
					be maintained to meet		
					requirement.		
					Other Residents that have th	ie	
					potential to be affected have		
					been identified by:		
					This deficit has the potential to	o	
					affect over 20 residents, staff		
					visitors. All areas assessed in		
					attic for penetration and		
					appropriate use of appropriate	,	
					firestop with required UL listin		
					and/or fire resistance rating.	-	

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLET	
		155525	B. W	NG		10/11/20	)23
NAME OF T	DROLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	t .	36 VALLEY DR				
SHADY N	NOOK CARE CENT	ER		LAWRE	ENCEBURG, IN 47025		
(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	TE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					Please see below measures		
					implemented to prevent		
					reoccurrence.		
					The measures or systemic changes that have been put		
					into place to ensure that the		
					deficient practice does not		
					recur include:		
					In-service completed with		
					maintenance director and		
				administrator. Review and pol	icy		
				initiated to ensure that when			
					maintenance repair and/or ver	ndors	
					are servicing facility that		
					maintenance director is follow	ing	
					with or directly after to ensure	that	
					penetration in fire barriers has		
					occurred. If penetration is pres		
					then maintenance director will		
					ensure that fire stop, with		
					appropriate fire resistance rati	-	
					and documentation, is in place		
					This will be discussed as part		
					operational morning and after	10011	
					meetings. The corrective action taken t		
					monitor performance to assu		
					compliance through quality		
					assurance:		
					A performance improvement t	ool	
					has been initiated to ensure th		
					fire walls have not been		
					penetrated. In addition to daily	,	
					rounds and monitoring for a		
					minimum of 3 months or until		
					substantial compliance is		
					achieved. A Quality Assurance	e	
					tool has been developed and		
					implemented to monitor the		
					compliance of fire barrier walls	s in	

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet Page 5 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL 10/11/	LETED
	PROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COI 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 CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with a	d means of egress shall not a latch or a lock that f a tool or key from the		accordance with regulation tool will be completed by maintenance director or weekly X 3 weeks, month months, then quarterly for quarters. Any identified is immediately be addressed outcomes will be reviewed the facility Quality Assurated program. Monitoring will as planned or will be increased to obtain 100% compliance. Additional a be taken by the Quality Assurance Committee, if warranted, based on the of the tools.  The date the systemic of will be completed: 10/12	the designee, hly X 3 or 2 ssues will ed. The ed through ance continue reased by ommittee, ction will  cutcome	
	special locking arr CLINICAL NEEDS LOCKING Where special loc	OR SECURITY THREAT				
	used, only one loc permitted on each be made for the ra by: remote control locks or keys carri	eds of the patient are king device shall be door and provisions shall upid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the				

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 6 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				LETED
		155525	B. W	ING		10/11	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	2			LEY DR		
SHADY	NOOK CARE CENT	FR			ENCEBURG, IN 47025		
SHADII	TOOK OF WE OLIVE			L/ \VVI\L			1
(X4) ID		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENT						
		king arrangements for the					
	-	e patient are used, all of					
		curity Locking requirements					
	-	addition, the locks must be					
		at fail safely so as to					
		of power to the device; the					
		ed by a supervised					
		er system and the locked					
	· ·	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 dillock the doors					
	18.2.2.2.5.2, 19.2	2 2 5 2 TIA 12-1					
	DELAYED-EGRE						
	ARRANGEMENT						
		lelayed-egress locking					
		in accordance with					
	7.2.1.6.1 shall be						
		g low and ordinary hazard					
		igs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2	-					
	ACCESS-CONTR						
	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	.2.4					
	ELEVATOR LOBE	BY EXIT ACCESS					
	LOCKING ARRAN	NGEMENTS					
	Elevator lobby exi	t access door locking in					
	accordance with 7	7 2 1 6 3 shall be permitted	1				1

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

Event ID:

 $K1NP21 \qquad {\tt Facility \, ID:} \quad 000304$ 

If continuation sheet

Page 7 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155525	B. W	ING		10/11/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	₹			LEY DR		
CHVDA I	NOOK CADE CENT	ED			ENCEBURG, IN 47025		
SHADTI	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	on door assemblie	es in buildings protected					
	throughout by an	approved, supervised					
	automatic fire dete	ection system and an					
	approved, supervi	sed automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2						
		on and interview, the facility	K 0	222	By submitting the enclosed		10/12/2023
		means of egress through 1 of			material, we are not admitting the		
	-	accessible for residents			truth or accuracy of any specif	ic	
		iagnosis requiring specialized			findings or allegations. We res	erve	
	security measures. Doors within a required means				the right to contest the finding:	s or	
	of egress shall not be equipped with a latch or				allegations as part of any		
	lock that requires the use of a tool or key from the				proceedings and submit these		
	egress side unless otherwise permitted by LSC				responses pursuant to our		
		ocking arrangements shall be			regulatory obligations. The fac	ility	
	_	ance with 19.2.2.2.5.2. This			requests that the plan of		
	_	ould affect over 20 residents,			correction be considered our		
	staff and visitors if	needing to exit the facility from			allegation of compliance effect	tive	
	the lower level.				11-02-23 for the Emergency		
					Preparedness survey date		
	Findings include:				10/11/23 and for the Life and		
					Safety recertification and state	)	
		ons with the Administrator			licensure survey conducted or		
		e Director during a tour of the			10/11/23. We respectfully requ	ıest	
		p.m. to 2:10 p.m. on 10/11/23, the			a paper review and will provide	e any	
		outside of the facility on the			additional information request	ed.	
		rked as a facility exit with an					
	-	or could be opened by entering					
		to a keypad at the exit door set			<u>K222</u>		
		ot posted to release the doors			It is the practice of this facility	to	
	_	with a clinical diagnosis			ensure that all egress doors a		
		ed security measures reside in			readily accessible for resident	s,	
		Based on interview at the time			without a clinical diagnosis		
		the Maintenance Director			requiring specialized security		
		set to the outside of the			measures, and staff.		
		wer level of the facility and also			The corrective action taken f	or	
		the outside of the facility if			those residents found to be		
		tairwell exit door on the upper			affected by the deficient		
		Based on interview at the time			practice include:		
	of the observations,	the Administrator and the			It is the policy of this facility to		

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet Page 8 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155525	A. BUILDING B. WING		
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	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION or agreed the code to release	TAG		DATE
		he outside of the facility on		ensure that egress doors, man as facility exit with exit signs,	Keu
		not posted at the exit door set.		have the 4- digit code present	with
	and to well to ver was not posited at the cities accer som			complete visibility to utilize eg	
	These findings were	e reviewed with the		doors. No residents or staff we	
	-	he Maintenance Director		affected. The exit door set to t	
	during the exit confe	erence.		outside of the facility exit, with	an
	<u> </u>			exit sign, has the 4-digit door	
	3.1-19(b)			visibly present. 8 of 8 egress	
				doors meet requirement.	
				Other Residents that have th	ie
				potential to be affected have	
				been identified by:	
				This deficit has the potential to	
				affect over 20 residents, staff	and
				visitors if needing to exit the	
				facility from the lower level. Al	
				egress doors were reviewed a	
				assessed to ensure in accorda	
				to meet compliance. Please se	
				below measures implemented	10
				prevent reoccurrence.	
				The measures or systemic changes that have been put	
				into place to ensure that the	
				deficient practice does not	
				recur include:	
				In-service completed with	
				maintenance director and	
				administrator. Review initiated	I to
				ensure that doors with a requi	red
				means of egress shall maintai	n
				compliance and meet regulation	
				This will be discussed as part	
				operational morning and after	noon
				meetings.	
				The corrective action taken t	
				monitor performance to assu	ure
				compliance through quality	
				assurance:	

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 9 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/11/2023			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR  LAWRENCEBURG, IN 47025					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRIDEFICIENCY)  A performance improvem has been initiated to ensure egress doors meet comply with 4-digit door codes vispresent. In addition to dain and monitoring for a minimonths or until substantial compliance is achieved. Assurance tool has been developed and implement monitor the compliance of doors in accordance with regulations. The tool will completed by the mainter director or designee, we weeks, monthly X 3 month quarterly for 2 quarters. A identified issues will immed be addressed. The outco be reviewed through the signal and the signal actions accordance with regulations. The tool will be addressed. The outco be reviewed through the signal actions accordance with regulations.	ent tool ure that iance sibly ily rounds mum of 3 al A Quality ted to f egress  oe nance kly X 3 hs, then kny ediately mes will facility			
K 0291 SS=D Bldg. 01		•		Quality Assurance program Monitoring will continue a planned or will be increased Quality Assurance Commended to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee, if warranted, based on the of the tools.  The date the systemic committed in the completed: 10/12	s sed by the hittee, if ction will coutcome hanges			

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 10 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155525	B. W	NG		10/11	/2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			LEY DR		
CLIADVA	JOOK CARE CENT	TED.					
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	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		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
	accordance with 7	7.9.					
	18.2.9.1, 19.2.9.1						
		on and interview, the facility	K 0291		By submitting the enclosed		10/12/2023
		f 13 battery powered			material, we are not admitting	the	
		systems was maintained in			truth or accuracy of any specif		
		SC Section 7.9. LSC 7.9.2.6			findings or allegations. We res		
	states battery operated emergency lights shall use				the right to contest the findings		
	only reliable types of rechargeable batteries				allegations as part of any	- <del>-</del> -	
	provided with suitable facilities for maintaining				proceedings and submit these		
	them in properly charged condition. Batteries				responses pursuant to our		
	used in such lights or units shall be approved for				regulatory obligations. The fac	ility	
	their intended use and shall comply with NFPA				requests that the plan of	illey	
	70, National Electric Code. This deficient practice				correction be considered our		
	could affect over 2 staff and visitors in the				allegation of compliance effect	ive	
	kitchen.				11-02-23 for the Emergency	iivo	
	Riterion.				Preparedness survey date		
	Findings include:				10/11/23 and for the Life and		
	i mamga meraac.			Safety recertification and state			
	Based on observation	ons with the Administrator			licensure survey conducted or		
		ce Director during a tour of the			10/11/23. We respectfully requ		
		p.m. to 2:10 p.m. on 10/11/23, the			a paper review and will provide		
	I -	hting system affixed to the			additional information requeste	-	
		s window to the dining room				Ju.	
		when its respective test button					
		e times. Based on interview at			<u>K291</u>		
		ervations, the Maintenance			It is the practice of this facility	to	
		aforementioned battery			ensure that all battery powered		
	_	y lighting system failed to			emergency lighting systems a		
		respective test button was			maintained in accordance with		
	pushed multiple tim	-			LSC Section 7.9, ensuring tha		
	pushed manapie im	ics.			they will illuminate.		
	These findings were	e reviewed with the			The corrective action taken f	or	
	1	the Maintenance Director			those residents found to be	<b>.</b> .	
	during the exit conf				affected by the deficient		
	daring the exit colli	erenee.			practice include:		
	3.1-19(b)				It is the policy of this facility to		
	J.1-17(0)				ensure that all battery-operate	d	
					lighting systems are maintaine		
						u	
					and have reliable types of		
					rechargeable batteries with		

PRINTED: 11/08/2023

	R MEDICARE & MEDIC					B NO. 0938-039
STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING				(X3) DATE SURVEY COMPLETED 10/11/2023	
	PROVIDER OR SUPPLIER		36 VAL	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	REGULATORY OF	A LOC IDENTIFITING INFORMATION	IAU	suitable facilities for maintain them in properly charged conditions. The emergency battery-operated lighting syst affixed to the wall above the window to the dining room hareliable, rechargeable battericand illuminates when the respective test button is push 13 of 13 battery powered emergency lighting systems requirement.  Other Residents that have the potential to be affected have been identified by: This deficit has the potential that affect 2 staff and visitors in the kitchen. All emergency batter operated lighting systems wereviewed and assessed to entin accordance to meet compliance. Please see below measures implemented to proreoccurrence.  The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: In-service completed with maintenance director and administrator. Review initiate ensure that battery operated emergency lighting shall main compliance and meet regulat. This will be discussed as part operational morning and after the operation of the propertic	d to ntain cions. t of	DATE

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

Event ID:

K1NP21

Facility ID: 000304

The corrective action taken to monitor performance to assure

meetings.

If continuation sheet

Page 12 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/11/2023
	PROVIDER OR SUPPLIER	36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 through quality assurance:  A performance improvement to has been initiated to ensure the 13/13 of battery-operated emergency lighting systems may compliance with reliable, rechargeable batteries to ensuillumination. In addition to daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved. A Quality Assurance tool has been developed and implemented to monitor the compliance of egress doors in accordance with regulations. Totol will be completed by the maintenance director or design weekly X 3 weeks, monthly X months, then quarterly for 2 quarters. Any identified issues immediately be addressed. The outcomes will be reviewed through the facility Quality Assurance program. Monitoring will continues planned or will be increase the Quality Assurance Commit if needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee, if warranted, based on the outcom of the tools.  The date the systemic change will be completed: 10/12/202	rat neet ure y  Fhe nee, 3 swill ne bough nue d by ttee, will ome

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: K1NP21 Facility ID: 000304 If continuation sheet Page 13 of 43

PRINTED: 11/08/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 10/11/2023
	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 LISC 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 0321 SS=D Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automation option is used, the from other spaces partitions and door Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel b. Laundries (large c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fee	are protected by a fire our fire resistance rating rated doors) or an inguishing system in 3.7.1 or 19.3.5.9. When the sic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in  Automatic Sprinkler N/A  -Fired Heater Rooms er than 100 square feet) mance, and Paint Shops from soms (exceeding 64 in Rooms lons) orage Rooms/Spaces			
	Hazard - see K32 Based on observation failed to ensure 1 of as fuel fired heater		K 0321	By submitting the enclosed material, we are not admitting truth or accuracy of any specif findings or allegations. We res	ic

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

doors. Doors shall be self closing or automatic

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

the right to contest the findings or

Page 14 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED	
MULLAN	OI CORRECTION	155525	B. WING			10/11/2023	
		100020	D. W			10/11/	2020
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					LEY DR		
SHADY N	NOOK CARE CENT	ER		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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	closing in accordan	ce with 7.2.1.8. This deficient			allegations as part of any		
	practice could affec	et over 2 staff and visitors on			proceedings and submit these	)	
	the lower level.				responses pursuant to our		
					regulatory obligations. The fac	cility	
	Findings include:				requests that the plan of		
					correction be considered our		
		ons with the Administrator			allegation of compliance effec	tive	
	and the Maintenanc	ee Director during a tour of the			11-02-23 for the Emergency		
	facility from 12:10	p.m. to 2:10 p.m. on 10/11/23, the			Preparedness survey date		
		unding a two inch in diameter			10/11/23 and for the Life and		
	pipe which penetrat	ted the ceiling above the water			Safety recertification and state	•	
	softener in the Mec	hanical Room on the lower			licensure survey conducted or	า	
	level was not firesto	opped. Two natural gas fired			10/11/23. We respectfully requ	uest	
	boilers were installe	ed in the room. Based on			a paper review and will provid	e any	
	interview at the tim	e of the observations, the			additional information request	ed.	
	Maintenance Direct	tor agreed the aforementioned					
	opening in the Mec	hanical Room ceiling did not					
	separate this hazard	lous area from other spaces			<u>K321</u>		
	with smoke resistan	nt partitions.			It is the practice of this facility	to	
					ensure that fuel, fired heater		
	_	e reviewed with the			rooms are separated from oth	er	
		the Maintenance Director			spaces by smoke resistant		
	during the exit conf	ference.			partitions and/or doors. That n		
					penetrations are present for 1		
	3.1-19(b)				13 of the noted hazardous are	as.	
					The corrective action taken f	or	
					those residents found to be		
					affected by the deficient		
					practice include:		
					It is the policy of this facility to		
					ensure that all hazardous area		
					are separated from other spac		
					by smoke resistant partitions.		
					annular space surrounding a t	WO	
					inch in diameter pipe which		
					penetrated the ceiling above the		
					water softener, in the Mechan		
					room, on the lower level is rep	aired	
					with drywall and appropriate		
					fire-resistant rated firestop in		

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 15 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	T 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 10/11/2023
	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)	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	place. 13 of 13 hazardous are are separated from other space by smoke resistant partitions a meet requirement.  Other Residents that have the potential to be affected have been identified by: This deficit has the potential to affect 2 staff members and vision the lower level. All hazardous areas, such as fuel, fired, hear rooms were reviewed and assessed to ensure in accordate to meet compliance. Please is below measures implemented prevent reoccurrence.  The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: In-service completed with maintenance director and administrator. Review initiated ensure that all hazardous area shall maintain compliance and meet regulations. This will be discussed as part of operation morning and afternoon meetir. The corrective action taken to monitor performance to assist compliance through quality assurance:  A performance improvement to has been initiated to ensure the 13/13 hazardous areas are separated from other spaces is smoke resistant partitions or doors. In addition to daily rour and monitoring for a minimum and minimum and monitoring for a minimum and minimu	as ces, and all control of the contr

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet

Page 16 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155525	A. BUILDING B. WING	01	COMPLETED 10/11/2023
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				months or until substantial compliance is achieved. A Qual Assurance tool has been developed and implemented to monitor the compliance of 13/1 hazardous areas in accordance with regulations. The tool will be completed by the maintenance director or designee, weekly X weeks, monthly X 3 months, the quarterly for 2 quarters. Any identified issues will immediate be addressed. The outcomes be reviewed through the facilitic Quality Assurance program. Monitoring will continue as planned or will be increased be Quality Assurance Committee needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee, if warranted, based on the outcome of the tools.  The date the systemic change will be completed: 10/12/2020.	on 13 see one one one one one one one one one o
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr	n - Testing and n is tested and maintained n an approved program requirements of NFPA 70, code, and NFPA 72, n and Signaling Code. n acceptance, maintenance			

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 17 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
ANDILAN	OI CORRECTION	155525	B. W		<u>01</u>	10/11/2023	
		100020	D. W	_		10/11/	2020
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
					LEY DR		
SHADY N	NOOK CARE CENT	ER		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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9.6.1.3, 9.6.1.5, N	IFPA 70, NFPA 72					
	1. Based on observa	ation and interview, the facility	K 0	345	By submitting the enclosed		11/02/2023
	failed to maintain tl	ne fire alarm system to ensure			material, we are not admitting	the	
	that it had accurate	time and date information in			truth or accuracy of any specif	fic	
	accordance with the	e requirements of NFPA 101-			findings or allegations. We res	serve	
	2012 edition, Section	ons 19.3.4 and 9.6 and NFPA 72			the right to contest the finding	s or	
	- 2010 edition, Sect	tions 14.1, 14.1.1. This deficient			allegations as part of any		
	practice could affect	et all residents, staff and			proceedings and submit these	)	
	visitors.				responses pursuant to our		
					regulatory obligations. The fac	cility	
	Findings include:				requests that the plan of	•	
	_				correction be considered our		
	Based on observation	ons with the Administrator			allegation of compliance effec	tive	
	and the Maintenanc	ee Director during a tour of the			11-02-23 for the Emergency		
		p.m. to 2:10 p.m. on 10/11/23, the			Preparedness survey date		
	-	ontrol panel located near the			10/11/23 and for the Life and		
		treet wing read the time of day			Safety recertification and state	9	
		:45 p.m. The main fire alarm			licensure survey conducted or		
	_	sprinkler riser room read the			10/11/23. We respectfully requ		
	_	4 p.m. at 1:07 p.m. Based on			a paper review and will provid		
	_	e of the observations, the			additional information request	-	
	Maintenance Direct	tor agreed the fire alarm system			· ·		
		accurate time of day.					
		-			<u>K345</u>		
	These findings were	e reviewed with the			It is the practice of this facility	to	
	Administrator and t	the Maintenance Director			maintain the fire alarm system		
	during the exit conf	ference.			ensure that the accurate time	and	
					date information is in accorda	nce	
	3.1-19(b)				with requirements.		
					The corrective action taken f	or	
	2. Based on record	review, observation and			those residents found to be		
	interview; the facili	ty failed to ensure all fire alarm			affected by the deficient		
	system initiating de	vices were inspected and			practice include:		
	tested in accordance	e with the schedules for			It is the policy of this facility to		
	inspection and testi	ng frequencies in NFPA 72.			ensure that all fire alarm syste		
	LSC 9.6.1.3 require	es a fire alarm system to be			are maintained and have the		
	installed, tested, and	d maintained in accordance			accurate time and date preser	nt on	
		ional Electrical Code and NFPA			the fire alarm system. The re		
		larm and Signaling Code.			fire alarm control panel locate		
		ition, Table 14.3.1 at 9(h) states			near the entrance to the D stre		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV	/EY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMPLETED	)
155525 B. WING 10/11/2023	3
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 PROVIDERS PLAN OF CORRECTION  FOR THE STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (STATEMENT OF DEFICIENCE I	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	MPLETION
	DATE
smoke detectors shall be visually inspected wing and the main fire alarm	
semiannually. NFPA 72, 2010 Edition, Table 14.4.5 control panel in the sprinkler room	
at 15(h) states smoke detectors shall be reflect the accurate time and date.	
functionally tested annually. NFPA 72, Table  All fire alarm systems reflect the	
14.3.1 at 9(f) states heat detectors shall be visually accurate date and time to meet	
inspected semiannually. NFPA 72, Section 14.4.5 requirement.	
states heat detector testing shall be performed in accordance with the schedules in Table 14.4.5.  Other Residents that have the potential to be affected have	
the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable affect all residents, staff, and visitors. All fire alarm systems are	
fixed-temperature, spot-type heat detectors shall  fixed-temperature, spot-type heat detectors shall  reviewed and assessed to ensure	
be tested in accordance with 14.4.5.5.1 through in accordance to meet	
on each initiating circuit annually. Different detectors shall be tested each year. NFPA 72, reoccurrence.	
2010 Edition, Table 14.4.2.2 at 14(d)(2) states  fixed-temperature, nonrestorable line type heat  The measures or systemic changes that have been put	
detectors functionality shall be tested into place to ensure that the	
mechanically and electrically. Loop resistance deficient practice does not	
shall be measured and recorded. Changes from recur include:	
acceptance test shall be investigated. Records  In-service completed with	
shall be kept by the building owner specifying maintenance director and	
which detectors have been tested. Within 5  administrator, Review initiated to	
years, each detector shall have been tested. This  years that all fire alarm systems	
deficient practice could affect over two staff.  deficient practice could affect over two staff.  shall maintain compliance and	
meet regulations. This will be	
Findings include: discussed as part of operational	
morning and afternoon meetings.	
Based on review of the fire alarm system  The corrective action taken to	
inspection contractor's "Smoke and Duct monitor performance to assure	
Detectors" section and "Heat & Carbon compliance through quality	
Monoxide Detectors" section of the "Fire Alarm assurance:	
System Inspection" report dated 02/09/23 with the  A performance improvement tool	
Administrator and the Maintenance Director has been initiated to ensure that	
during record review from 8:45 a.m. to 12:10 p.m.  all fire alarm systems meet	
on 10/11/23, no smoke detectors or heat detectors compliance in maintaining	
in the elevator machine room were listed as being accurate date and time. In addition	
inspected or tested within the most recent twelve to daily rounds and monitoring for	

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet Page 19 of 43

	NT 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 10/11/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR  LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
TAG	month period. Base record review, the I additional fire alarm most recent twelve available for review elevator machine rowith the Administra Director during a top.m. to 2:10 p.m. or installed in the based and of the observat Director agreed it c system testing documachine room initiatesting within the machine room initiatesting within the machine findings were	ed on interview at the time of Maintenance Director stated in testing documentation for the month period was not and stated the facility has one form. Based on observations after and the Maintenance four of the facility from 12:10 in 10/11/23, a heat detector was rement elevator machine room. The time of record review from the Maintenance fould not be ensured fire alarm from the month of the month of the month of the Maintenance for the month of the Maintenance for the Maintenance for the month of the Maintenance for the	TAG	a minimum of 3 months or un substantial compliance is achieved. A Quality Assurant tool has been developed and implemented to monitor the compliance of fire alarm systin accordance with regulation. The tool will be completed by maintenance director or desi weekly X 3 weeks, monthly 2 months, then quarterly for 2 quarters. Any identified issue immediately be addressed. Toutcomes will be reviewed the facility Quality Assurance program. Monitoring will compose as planned or will be increased the Quality Assurance Commit needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee, if warranted, based on the outroof the tools.  The date the systemic charmonic will be completed: 11/02/20.  By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We response pursuant to our regulatory obligations. The farequests that the plan of correction be considered our allegation of compliance effects.	ems, es. / the gnee, (3 a ses will The arough estinue ed by enittee, en will come eges 23 a g the cific eserve gs or se acility ective	

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	E SURVEY LETED 1/2023
	ROVIDER OR SUPPLIE		36 VAL	ADDRESS, CITY, STATE, ZIP CO LEY DR ENCEBURG, IN 47025	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
				Preparedness survey of 10/11/23 and for the Lit Safety recertification ar licensure survey condu 10/11/23. We respectful a paper review and will additional information r	fe and nd state acted on ally request provide any	
				K345  It is the practice of this ensure that all fire alarr initiating devices are in and tested in accordan schedules for inspectio testing frequencies and that record keeping is passecifying which have tested.  The corrective action those residents found affected by the deficie	m system spected ce with the n and I to ensure present been taken for I to be	
				practice include: It is the policy of this fa ensure that all fire alarr initiating devices are in and tested in accordan schedules for inspectio testing frequencies for It is the policy of the fac	cility to n system spected ce with the n and the facility.	
				ensure that record keep present specifying what tested. Record reflects ensures that fire alarm testing documentation the elevator machine reinitiating device inspect testing within the most twelve-month period. Asystem initiating devices	ping is t has been and system includes com tion and recent All fire alarm	

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 21 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPI 10/11	
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COLLEY DR	OD	
SHADY N	NOOK CARE CENT	ER	LAWR	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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				inspected in accordance schedules for inspection testing frequencies, reckeeping is present to reensure compliance.  Other Residents that it potential to be affected been identified by: This deficit has the potential to be affect over two staff. All system initiating devices reviewed and assessed record keeping ensurin accordance to meet concurrence. The measures or system changes that have been into place to ensure the deficient practice does recur include: In-service completed with maintenance director and administrator. Review it maintenance director and administrator. Review it maintenance director and safecare, to ensure the alarm system initiating inspected and added, and warranted, to testing free and scheduling to mainten compliance and meet in This will be discussed and operational morning and meetings.  The corrective action of monitor performance of compliance through quassurance: A performance improves	e with the in and cord effect to have the diffect to have the difference ential to a fire alarm estate ential to a fire ential the ential the ential the ential fire devices are as equency atain egulations. Eas part of difference ential to assure to a fire ential to a fire enti	

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet Page 22 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DATE SI COMPLE	
		155525	B. W	B. WING		10/11/2023	
SHADY I	PROVIDER OR SUPPLIER	ER		36 VAL LAWRE	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, 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' DEFICIENCY)	TE	(X5) COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	has been initiated to ensure the all fire alarm system initiating devices are inspected with test frequencies to meet compliance. The facility conducted, with maintenance director and Safecare, the initial inspection initiating devices located in the facility and the scheduling frequency audit. A quality assurance tool has been developed and implemented formaintenance director, or design to audit Safecares inspection the fire alarm system initiating devices record quarterly X 4 quarters, ensuring proper inspection and record keeping all devices. The compliance at will continue until substantial compliance is achieved, in accordance with regulations. A identified issues will immediate be addressed. The outcomes be reviewed through the facilit Quality Assurance program. Monitoring will continue as planned or will be increased by Quality Assurance Committee in needed to obtain 100% compliance. Additional action of the tools.  The date the systemic change will be completed: 11/02/2023	at ting ce.  of ec.  or the inee, of did the inee, of din	DATE

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet

Page 23 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155525	B. WI	NG		10/11/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			36 VALI			
SHADVI	IOOK CARE CENT	FR			NCEBURG, IN 47025		
OHADI N	OOK CARL CLIVE	LIX		LAVVINL	INCEBONG, IN 47023		
(X4) ID	SUMMARY S	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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0351	NFPA 101						
SS=E	Sprinkler System -	· Installation					
Bldg. 01	Spinkler System -	Installation					
	2012 EXISTING						
	Nursing homes, ar	nd hospitals where required					
	by construction type						
		approved automatic					
	•	n accordance with NFPA					
		ne Installation of Sprinkler					
	Systems.						
	• •	nstruction, alternative					
	•	es are permitted to be					
	·	inkler protection in specific					
		or local regulations prohibit					
	sprinklers.						
		klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
	•	sprinkler coverage covers					
	•	t as required by NFPA 13,					
	Standard for Insta	liation of Sprinkler					
	Systems.	10.050.40.054					
		19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)	17.0		D		11/02/2022
		ation and interview, the facility omplete automatic sprinkler	K 0.	331	By submitting the enclosed	41	11/02/2023
		d in accordance with NFPA 13,			material, we are not admitting		
	-	ard for the Installation of			truth or accuracy of any specif findings or allegations. We res		
		to provide complete coverage					
		he building. NFPA 13, Section			the right to contest the findings allegations as part of any	, OI	
	-	Distance between Sprinklers",			proceedings and submit these		
		ll be spaced not less than 6			responses pursuant to our		
	-	dition, LSC 4.6.7.5 requires			regulatory obligations. The fac	ility	
		Ceatures that do not meet the			requests that the plan of	y	
		w buildings, but exceed the			correction be considered our		
	-	isting buildings shall not be			allegation of compliance effect	ive	
	-	This deficient practice could			11-02-23 for the Emergency		
		ents, staff and visitors in the			Preparedness survey date		
		en storage room for the			10/11/23 and for the Life and		
	facility.	• · · · · · · · · · · · · · · · · · · ·			Safety recertification and state	,	
	•		I		,		

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet Page 24 of 43

PRINTED: 11/08/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155525	B. W	ING		10/11/	2023
NAME OF I	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD LEY DR		
CLIADV	NOOK CADE CENT	TD.					
SHADYI	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
					licensure survey conducted or		
	Findings include:				10/11/23. We respectfully requ	uest	
					a paper review and will provide	e any	
	Based on observation	ons with the Administrator			additional information requeste	ed.	
	and the Maintenanc	e Director during a tour of the					
	facility from 12:10 p.m. to 2:10 p.m. on 10/11/23,						
	two separate ceiling	g mounted sprinklers are			<u>K351</u>		
	installed four and one half feet from one another				It is the practice of this facility	to	
	in the oxygen storage room by the elevator. One				ensure that the minimum dista	ance	
	of the sprinklers is installed near the center of the room and the second sprinkler is installed near one of the four walls. 108 'E' type oxygen cylinders were stored in the room. Based on				between sprinklers is maintain	ned,	
					ensuring that they are spaced	not	
					less than 6 feet on the center.		
					The corrective action taken f	or	
	interview at the time of the observations, the				those residents found to be		
	Maintenance Direct	or agreed the two ceiling			affected by the deficient		
	mounted sprinklers	were spaced less than 6 feet			practice include:		
	apart.				It is the policy of this facility to		
					ensure that all sprinklers meet	t the	
	These findings were	e reviewed with the			required minimum distance		
	Administrator and t	he Maintenance Director			between sprinklers. One of the	ne	
	during the exit conf	erence.			two separate ceiling mounted		
					sprinklers that are installed for	ur-	
	3.1-19(b)				and one-half feet from one and	other	
					in the oxygen storage room by	/ the	
	2. Based on observa	ation and interview, the facility			elevator, has a current work o	rder	
	failed to ensure the	deflectors for 1 of 2 ceiling			in place for Safecare to remov	e the	
	mounted sprinklers	in the oxygen storage room for			additional sprinkler not require	ed.	
	the facility were ins	stalled parallel to the slope of			All sprinklers meet the require	d	
	the ceiling. NFPA	13, Standard for the Installation			minimum distance between		
	of Sprinkler System	ns, 2010 Edition, Section 8.5.4.2			sprinklers throughout the facili	ity.	
	states deflectors of	sprinklers shall be aligned			Other Residents that have th	-	
	parallel to ceilings,	roofs, or the incline of stairs.			potential to be affected have		
	This deficient pract	ice could affect over 10			been identified by:		
	residents, staff and	visitors in the vicinity of the			This deficit has the potential to	o	
	oxygen storage rooi	m for the facility.			affect over 10 residents, staff,		
		•			visitors in the vicinity of the		
	Findings include:				oxygen storage room for the		
	_				facility. All sprinklers are revie	wed	
	Based on observation	ons with the Administrator			and assessed to ensure in		

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

Based on observations with the Administrator and the Maintenance Director during a tour of the

Event ID:

K1NP21

Facility ID: 000304

accordance to meet compliance.

If continuation sheet

Page 25 of 43

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155525	B. WI	NG		10/11/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LEY DR		
SHADY	NOOK CARE CEN	TER			ENCEBURG, IN 47025		
	TOOK OF IKE CENT				110280110, 111 17020		T
(X4) ID		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	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		p.m. to 2:10 p.m. on 10/11/23, the			Please see below measures		
		iling mounted sprinkler nearest			implemented to prevent		
		stalled parallel to the ceiling in			reoccurrence.		
	the oxygen storage room for the facility. Based on interview at the time of the observations, the Maintenance Director agreed the ceiling mounted sprinkler nearest the wall in the oxygen storage room was not properly installed.				The measures or systemic		
					changes that have been put		
					into place to ensure that the		
					deficient practice does not		
					recur include:		
					In-service completed with		
		re reviewed with the			maintenance director and		
		the Maintenance Director			administrator. Review initiated		
during the exit conference.				ensure that all sprinklers main			
					compliance and meet regulation		
	3.1-19(b)				This will be discussed as part		
					operational morning and after	noon	
		ration and interview, the facility			meetings.		
		he ceiling construction in 1 of 1			The corrective action taken t		
		oms in accordance with NFPA			monitor performance to assu	ıre	
		e Installation of Sprinkler			compliance through quality		
		3, 2010 edition, Section 6.2.7.1			assurance:		
	_	cheons, or other devices used			A performance improvement t		
		ar space around a sprinkler shall			has been initiated to ensure th		
		l be listed for use around a			all sprinklers meet compliance	e for	
	_	cient practice could affect over			minimum distance between		
		and visitors in the vicinity of			sprinklers. A Quality Assurance	е	
	the D Street showe	r room.			tool has been developed and		
					implemented to monitor the		
	Findings include:				compliance of all sprinklers,		
	l				meeting minimum distance in		
		ons with the Administrator			accordance with regulations.	The	
		ce Director during a tour of the			tool will be completed by the		
	-	p.m. to 2:10 p.m. on 10/11/23, the			maintenance director or desig		
		rinkler in the closet of the D			annually. Any identified issues		
		n by Room 41 was missing its			immediately be addressed. Th		
		exposed the attic above. Based			outcomes will be reviewed thr	ough	
		time of the observations, the			the facility Quality Assurance		
		tor agreed the aforementioned			program. Monitoring will conti		
	sprinkler location v	was missing its escutcheon.			as planned or will be increase	•	
					the Quality Assurance Commi	ttee,	
I	I These findings wer	e reviewed with the	1		if needed to obtain 100%		I

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPL	ETED
		155525	B. WIN	NG		10/11/	2023
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R					
CLIADYA	NOOK OADE OENI	TED.			LEY DR		
SHADY	NOOK CARE CENT	IER		LAWRE	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	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
	Administrator and	the Maintenance Director			compliance. Additional action	will	
	during the exit con	ference.			be taken by the Quality		
				Assurance Committee, if			
	3.1-19(b)				warranted, based on the outco	ome	
					of the tools.		
					The date the systemic chang	es	
					will be completed: 11/02/2023	3	
					By submitting the enclosed		
					material, we are not admitting	the	
					truth or accuracy of any specif	ic	
					findings or allegations. We res		
					the right to contest the findings	s or	
					allegations as part of any		
					proceedings and submit these	;	
					responses pursuant to our		
					regulatory obligations. The fac	ility	
					requests that the plan of		
					correction be considered our		
					allegation of compliance effect	tive	
					11-02-23 for the Emergency		
					Preparedness survey date		
					10/11/23 and for the Life and		
					Safety recertification and state		
					licensure survey conducted or		
					10/11/23. We respectfully requ		
					a paper review and will provide		
					additional information requeste	∌u.	
					V254		
					K351 It is the practice of this facility	to	
					ensure the escutcheon is pres		
					for all mounted sprinklers in th		
					facility.	Č	
					The corrective action taken f	or	
					those residents found to be	٠.	
					affected by the deficient		
					practice include:		
					It is the policy of this facility to		
I	ĺ		1		I it is the policy of this facility to	ļ	

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

Event ID:

 $K1NP21 \qquad {\tt Facility \, ID:} \quad 000304$ 

If continuation sheet Page 27 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155525	B. W	ING		10/11	
				T			-
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
0	1001/04== 0=::=				LEY DR		
SHADY	NOOK CARE CENT	ER		LAWRENCEBURG, IN 47025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDAVIDEDIC DI AN OF CORDECTION		(X5)
PREFIX		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	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.10	DATE
					ensure that all mounted sprink	ders	
					have escutcheon in place. The		
					ceiling mounted sprinkler in th		
					closet of the D street shower r		
					by room 41 has escutcheon in	1	
					place. All escutcheons for		
					mounted sprinklers meet the		
					requirement for proper installa	ition.	
				Other Residents that have th			
					potential to be affected have		
					been identified by:		
					This deficit has the potential to	)	
					affect over 10 residents, staff,	and	
					visitors in the vicinity of the D		
					street shower room. All sprink	lers	
					are reviewed and assessed to	1	
					ensure in accordance to meet		
					compliance. Please see below	1	
					measures implemented to pre	vent	
					reoccurrence.		
					The measures or systemic		
					changes that have been put		
					into place to ensure that the		
					deficient practice does not		
					recur include:		
					In-service completed with		
					maintenance director and		
					administrator. Review initiated		
					ensure that all mounted sprink	ders	
					are properly installed, with	_	
					escutcheon in place, to maint		
					compliance and meet regulation		
					This will be discussed as part		
					operational morning and after	noon	
					meetings.		
					The corrective action taken t		
					monitor performance to assu	ıre	
					compliance through quality		
	I		1		assurance:		I

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

A performance improvement tool

Page 28 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155525	B. W	NG		10/11/	2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		36 VAL	LEY DR		
SHADY N	NOOK CARE CEN	TER		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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					has been initiated to ensure the		
					all sprinklers meet compliance	or	
					properly installed mounted	in	
					sprinklers, with escutcheon(s) place. A Quality Assurance to		
					has been developed and	OI	
					implemented to monitor the		
					compliance of all mounted		
					sprinklers to ensure escutched	on(s)	
					are in place. The tool will be	511(5)	
					completed by the maintenance	e	
					director or designee, weekly >		
					weeks, monthly X 3 months, t		
					quarterly for 2 quarters. Any		
					identified issues will immediat	ely	
					be addressed. The outcomes	will	
					be reviewed through the facilit	ty	
					Quality Assurance program.		
					Monitoring will continue as		
					planned or will be increased b	y the	
					Quality Assurance Committee	, if	
					needed to obtain 100%		
					compliance. Additional action	will	
					be taken by the Quality		
					Assurance Committee, if		
					warranted, based on the outco	ome	
					of the tools.		
					The date the systemic chang	jes	
					will be completed: 11/02/202		
					By submitting the enclosed		
					material, we are not admitting	the	
					truth or accuracy of any speci	fic	
					findings or allegations. We res	serve	
					the right to contest the finding	s or	
					allegations as part of any		
					proceedings and submit these	;	
					responses pursuant to our		
					regulatory obligations. The fac	cility	
					requests that the plan of		

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 29 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER  155525		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/11/2023	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD		
SHADY N	IOOK CARE CENT	ER		ALLEY DR RENCEBURG, 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 APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
				correction be considered our allegation of compliance effect 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and stat licensure survey conducted of 10/11/23. We respectfully require a paper review and will provide additional information requesting.	e n uest de any	
				<u>K351</u> It is the practice of this facility	to	
				ensure that all mounted sprin		
				are installed parallel to the ce roofs or incline of stairs.	iling,	
				The corrective action taken	for	
				those residents found to be		
				affected by the deficient		
				practice include:  It is the policy of this facility to		
				ensure that all mounted sprin		
				are installed properly. The ce	l l	
				mounted sprinkler nearest the	·	
				in the oxygen storage room h		
				current work order to be remo		
				as it also does meet the minir distance and an additional	num	
				sprinkler is not needed. All		
				mounted sprinklers were revi	ewed	
				to ensure they meet the		
				requirement for proper installa	ation.	
				Other Residents that have the		
				potential to be affected have		
				been identified by:		
				This deficit has the potential t	l l	
				affect over 10 residents, staff	, and	
				visitors in the vicinity of the		
			1	oxygen storage room for the	ı	

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet

Page 30 of 43

11/08/2023 PRINTED:

DEPARTMENT CENTERS FOI	FORM APPROVED 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 01	(X3) DATE SURVEY COMPLETED 10/11/2023	
NAME OF I	PROVIDER OR SUPPLIEF	- L		ADDRESS, CITY, STATE, ZIP COD		
SHADY I	NOOK CARE CENT	ER		LLEY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
IAU	REGULATORY OF	A LOC IDENTIFITING INFORMATION	TAU	facility. All mounted sprinklers reviewed and assessed to en in accordance to meet compliance. Please see below measures implemented to pre reoccurrence.  The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:  In-service completed with maintenance director and administrator. Review initiated ensure that all mounted sprin are properly installed to maintenance and meet regulated. This will be discussed as part operational morning and after meetings.  The corrective action taken monitor performance to assecompliance through quality assurance:  A performance improvement has been initiated to ensure that all mounted sprinklers meet compliance for proper installed. A Quality Assurance tool has been developed and implement to monitor the compliance of amounted sprinklers to ensure remain properly installed. The will be completed by the maintenance director or designed weekly X 3 weeks, monthly X months, then quarterly for 2 quarters. Any identified issues	d to klers tain ions. t of rnoon  to tool hat ment.  ented all they e tool gnee, 3	

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

Event ID:

K1NP21

Facility ID: 000304

immediately be addressed. The outcomes will be reviewed through

If continuation sheet

Page 31 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155525	B. WI	NG		10/11/	2023
NAME OF I	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD		
	NOOK CARE CEN				LEY DR ENCEBURG, IN 47025		
	Г				-NOLDONG, IN 47020		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
					CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System Sprinkler System Automatic sprinkl are inspected, tes accordance with I Inspection, Testir Water-based Fire Records of syster inspection and tes secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record re	RKS information on non-required or partial er system. 8, and NFPA 25 view and interview, the facility	K 0.	PREFIX TAG	the facility Quality Assurance program. Monitoring will conti as planned or will be increase the Quality Assurance Commif needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee, if warranted, based on the outcof the tools.  The date the systemic change will be completed: 11/02/202	nue d by ittee, will ome	COMPLETION DATE
		automatic sprinkler systems in			material, we are not admitting	the	

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

Event ID:

K1NP21

Facility ID: 000304

304 I

If continuation sheet Page 32 of 43

PRINTED: 11/08/2023

	Γ OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) M	III TIDI E CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	ľ í	ЛLDING	01	COMPI	
ANDILAN	OF CORRECTION	155525	B. W.		01	10/11	
		199929	D. W	_		10/11	72023
NAME OF	PROVIDER OR SUPPLIE	TR.			ADDRESS, CITY, STATE, ZIP COD		
TVIVIL OF	ROVIDER OR SOLVER			36 VAL	LEY DR		
SHADY	NOOK CARE CEN	TER		LAWR	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	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with N	FPA 25. LSC 9.7.5 requires all			truth or accuracy of any spec	ific	
	sprinkler systems s	shall be inspected, tested, and			findings or allegations. We re	serve	
	maintained in acco	ordance with NFPA 25, Standard			the right to contest the finding	s or	
	for the Inspection,	Testing, and Maintenance of			allegations as part of any		
	Water-Based Fire	Protection Systems. NFPA 25,			proceedings and submit these	е	
	2011 Edition, Section 5.3.1.1.1.6 states dry				responses pursuant to our		
	sprinklers that hav	e been in service for 10 years			regulatory obligations. The fa	cility	
	shall be replaced o	r representative samples shall			requests that the plan of		
	be tested and then retested at 10-year intervals. NFPA 25, Section 4.1.4.1 states the property				correction be considered our		
					allegation of compliance effect	ctive	
	owner or designate	ed representative shall correct			11-02-23 for the Emergency		
	or repair deficience	ies or impairments that are			Preparedness survey date		
	found during the in	nspection, test and maintenance			10/11/23 and for the Life and		
	required by this sta	andard. Corrections and repairs			Safety recertification and stat	е	
	shall be performed	by qualified maintenance	licensure survey conducted on		n		
	personnel or a qua	lified contractor. NFPA 25,			10/11/23. We respectfully req	uest	
	4.3.1 requires reco	ords shall be made for all	a paper review and will provide a		le any		
	inspections, tests,	and maintenance of the system			additional information reques	ted.	
	components and sh	nall be made available to the					
	authority having ju	arisdiction upon request. This					
	deficient practice of	could affect all residents, staff,			<u>K353</u>		
	and visitors in the	facility.			It is the practice of this facility	to	
					ensure that automatic sprinkle	ers	
	Findings include:				are inspected, tested and		
					maintained per regulation and	t	
	Based on review o	f the sprinkler system			record keeping is present.		
	inspection contract				The corrective action taken	for	
	_	t" documentation dated			those residents found to be		
		Administrator and the			affected by the deficient		
		ctor during record review from			practice include:		
		p.m. on 10/11/23, four dry			It is the policy of this facility to		
		were sent out for testing and			ensure that automatic sprinkle	ers	
	•	n new sprinklers on 11/07/19.			are inspected, tested and		
		the results of sprinkler testing			maintained in accordance wit	h	
		9 was not available for review.			regulation and proper record		
	Based on interview	v at the time of record review,			keeping is present. The form,	titled	1

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

the Administrator and the Maintenance Director

tried to obtain documentation from the sprinkler

inspection contractor but stated the contractor's

company was subsequently sold and agreed

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

"Work Acknowledgement" showed

documentation could be retrieved

the four dry pendent sprinklers

were sent out but no further

Page 33 of 43

11/08/2023 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 10/11/2023 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE documentation of the results of sprinkler testing with documentation regarding the on or after 11/07/19 was not available for review. results of this testing. Safecare Based on interview at the time of record review, work order is in place to ensure the Administrator and the Maintenance Director testing is completed and record is stated they were not aware if any additional kept at facility. sprinkler testing or replacement by a different Other Residents that have the contractor was conducted on or after 11/07/19. potential to be affected have been identified by: These findings were reviewed with the This deficit has the potential to Administrator and the Maintenance Director affect all staff, all residents and all during the exit conference. visitors. Safecare work order in place to ensure compliance is 3.1-19(b)met. Please see below measures implemented to prevent reoccurrence. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: In-service completed with maintenance director and administrator. Initially effort was towards locating documentation of completed service but the contracted business, no longer in business, was unable to provide this documentation. Once unable to locate, an immediate work order was placed to ensure proper inspection, testing and maintaining of water-based fire protection is in place with proper record keeping. The corrective action taken to monitor performance to assure compliance through quality

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

Event ID:

K1NP21

Facility ID: 000304

assurance:

If continuation sheet

Once the Safecare work order is completed, the record will be

Page 34 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	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  10/11/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
SHADY N	NOOK CARE CENT	ER		LEY DR ENCEBURG, IN 47025		
(X4) ID	SUMMARY S	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 OR	LSC IDENTIFYING INFORMATION	TAG	maintained. Inspection, testing and maintaining of water-base protection systems will be completed to meet compliance this regulation, ensuring 100% compliance with testing requirements. Additional action will be taken by the Quality Assurance Committee, if warranted.  The date the systemic change will be completed: 11/02/202	ed fire e for 6 n	
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or complement of Clearance between covering is not except the door closed with a context of the door closed with a context of the covering is not except the covering with a context of t	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain				

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 35 of 43

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	l í	ILDING	01	COMPL	
		155525	B. WI	NG		10/11	/2023
		L		CTDEET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD LEY DR		
SHVDV	NOOK CARE CENT	rer -			ENCEBURG, IN 47025		
SHADII	NOON CARE CENT	I LIX		LAWKE	-NOLDONG, IN 47020		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY 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
	1 -	ors. Hold open devices that					
		door is pushed or pulled are					
		ed protective plates of					
	_	re permitted. Dutch doors					1
	meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or						
		compliance with 8.3,					
	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire						1
							1
		ictions in area or lire is or frames in window					
	assemblies.						
	assembles.						
	19.3.6.3. 42 CFR	Parts 403, 418, 460, 482,					
	483, and 485	,,,					
	1	KS details of doors such as					
		ngs, automatics closing				1	
	devices, etc.	•					
	Based on observati	on and interview, the facility	K 03	363	By submitting the enclosed		10/16/2023
		f 47 corridor doors to resident			material, we are not admitting	the	
		uld resist the passage of			truth or accuracy of any speci		
		ent practice could affect over			findings or allegations. We re		
	40 residents, staff a	and visitors.			the right to contest the finding	s or	
					allegations as part of any		
	Findings include:				proceedings and submit these	9	
	D 1 1	Mala Adams A			responses pursuant to our		
		ons with the Administrator			regulatory obligations. The factors are	cility	
		ce Director during a tour of the			requests that the plan of		
		p.m. to 2:10 p.m. on 10/11/23, the			correction be considered our	utis co	
		sident sleeping Room 24 and hed into the door frame when			allegation of compliance effect	uve	
		a one and a half inch gap was			11-02-23 for the Emergency		
		ne face of the door and the			Preparedness survey date 10/11/23 and for the Life and		
					Safety recertification and state	2	
	door stop on the door frame near the top of the door. The corridor door to Room 33 latched into				licensure survey conducted o		
		en tested to close but a one			10/11/23. We respectfully req		
		in between the face of the			a paper review and will provide		
		stop on the door frame near the			additional information request	-	
		ased on interview at the time of			a a a a a a a a a a a a a a a a a a a	<b></b>	

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 36 of 43

PRINTED: 11/08/2023

	T OF HEALTH AND HU! R MEDICARE & MEDIC					APPROVED O. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/11/2023		
NAME OF 1	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD LLEY DR			
SHADY	NOOK CARE CENT	ER	LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG  the agr wo doo pos	SUMMARY (EACH DEFICIEN REGULATORY OF the observations, th agreed the aforement would not resist the doors were in the fu position. These findings were	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  e Maintenance Director ntioned three corridor doors passage of smoke when the fully closed and latched  e reviewed with the the Maintenance Director			to there tre of for to tto tto tto There tre tre tre tre tre tre tre tre tre	(X5) OMPLETION DATE	
				passage of smoke.  Other Residents that have the potential to be affected have been identified by:  This deficit has the potential the affect over 40 residents, staffing visitors. All corridor doors were reviewed and assessed to entine accordance to meet compliance. Please see below measures implemented to prefere occurrence.  The measures or systemic changes that have been put into place to ensure that the	e o o, and re sure w event		

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

Event ID:

K1NP21

Facility ID: 000304

recur include:

deficient practice does not

In-service completed with maintenance director and

If continuation sheet

Page 37 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155525	A. BUILDING B. WING	01	COMPLETED 10/11/2023
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				administrator. Review initiated ensure that all corridor doors no impediment to closing and preventing the passage of sm to maintain compliance and m regulations. This will be discurance part of operational morning afternoon meetings.  The corrective action taken monitor performance to assistem compliance through quality assurance:  A performance improvement of the passage smoke. A Quality Assurance of the passage smoke. A Quality Assurance of the passage of sm the tool will be completed by maintenance of all corridor door ensure they remain able to clopreventing the passage of sm the tool will be completed by maintenance director or design weekly X 3 weeks, monthly X months, then quarterly for 2 quarters. Any identified issues immediately be addressed. The outcomes will be reviewed that the facility Quality Assurance program. Monitoring will continuate planned or will be increased the Quality Assurance Committee, if warranted, based on the outco of the tools.	show oke neet ssed g and to ure  tool nat ance of cool  rs to ose oke. the inee, 3 s will ne rough nue ed by ittee, will

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 38 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		<u>01</u>	COMPLETED			
155525		B. WING		10/11/2023				
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR				
SHADY N	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			1110			DATE	
					The date the systemic chang will be completed: 10/16/2023			
K 0521 SS=F Bldg. 01	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		K 0.	521	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested.  K521  The facility has been granted a waiver for K021 each year since 1990, when the tag was first cited. Following the 1990 survey, the facility had installed a system whereby the activation of the fire alarm, including the automatic		11/02/2023	

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

Event ID:

 $K1NP21 \qquad {\tt Facility \, ID:} \quad 000304$ 

If continuation sheet Page 39 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/11/2023
	PROVIDER OR SUPPLIE		36 VAL	ADDRESS, CITY, STATE, ZIP COD LLEY 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ON (X5) BE COMPLETION DATE
		re reviewed with the the Maintenance Director ference.		sprinkler system and the automatic smoke detection shut down the supply air fall	
	3.1-19(b)			In 1990, the facility obtained estimate from a contractor install return air ducts in ear resident's room. The cost at time was approximately \$29,782.00.	to ich
				All fire protection devices a tested by Safe Care on an abasis.	
				Sprinkler system tested by Care quarterly. Facility maintenance conducts fire quarterly on shifts (1) and ( alarm is tripped.	drills
K 0531 SS=D Bldg. 01	Elevators are inspecified in ASMI Elevators and Es Service is operatore record.	with the provision of 9.4. pected and tested as E A17.1, Safety Code for calators. Firefighter's ed monthly with a written			

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet Page 40 of 43

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 10/11/2023				
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			36 VAI	STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR 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			
	and Escalators. All a travel distance of below the level that emergency person purposes, conform Requirements of A (Includes firefighter recall and smoke of firefighter's service key operation, madetectors, and eledetectors.)  19.5.3, 9.4.2, 9.4.3  Based on record revinterview; the facility elevators were equifor 1 of 1 sprinkleres Standard for the Instruction 8.15.5.3 state elevator machine rowintermediate temper A17.1 permits sprint rooms when there is the main power sup automatically upon, water from the sprint machine room. NF any occupancy when fire is such that extitiaccomplished by a textinguishing system sprinkler system, such accordance with the determined in accordanc	view, observation and ty failed to ensure 1 of 1 pped with shunt trip devices and machine rooms. NFPA 13, tallation of Sprinkler Systems, tes automatic sprinklers in soms shall be of ordinary or rature rating. ASME/ANSI alklers in elevator machine is a means for disconnecting ply to the affected elevator if or prior to, the application of alkler located in the elevator PA 101, Section 9.7.3.1 states in the character of the fuel for inguishment or control of fire is	K 0531	By submitting the enclosed material, we are not admitting truth or accuracy of any spec findings or allegations. We re the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farequests that the plan of correction be considered our allegation of compliance effect 11-02-23 for the Emergency Preparedness survey date 10/11/23 and for the Life and Safety recertification and state licensure survey conducted of 10/11/23. We respectfully require a paper review and will provide additional information requesting.  **ES31**  It is the practice of this facility ensure that the elevator is equipped with a shunt trip desired.	ific serve gs or e cility ctive e en quest de any ted.			

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

Event ID:

K1NP21

Facility ID: 000304

If continuation sheet

Page 41 of 43

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>		COMPLETED		
		155525			10/11/	2023	
				CTREET	ADDRESS CITY STATE ZIP COP		
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
OLIA DVA	JOOK OADE OENT	····			LEY 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 DEFICIEN	CY 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
	system that is not in	nstalled in lieu of a required,			for sprinklered machine rooms	S.	
	supervised automat	ic sprinkler system shall be			The corrective action taken f	or	
	indicated at the buil	ding fire alarm system, where			those residents found to be		
	provided. This defi	cient practice could affect over			affected by the deficient		
	two staff and visitor	rs.			practice include:		
					It is the policy of this facility to		
	Findings include:				ensure that that the elevator is	3	
					equipped with a shunt trip dev	rice	
	Based on review of	the fire alarm system			and is identifiable by the facilit	y. It	
	inspection contracto	or's "Smoke and Duct			is the policy of the facility to		
	Detectors" section a	and "Heat & Carbon			ensure that all heat detectors	are	
	Monoxide Detector	s" section of the "Fire Alarm			inspected, and that the inspec	tion	
	System Inspection" report dated 02/09/23 with the			is kept on record for review. The			
	Administrator and the Maintenance Director				elevator shunt trip device loca	tion	
	during record review from 8:45 a.m. to 12:10 p.m.				is able to be identified and the	!	
	on 10/11/23, no smoke detectors or heat detectors				heat detector located in the		
	in the elevator machine room were listed as being				elevator room is inspected to	meet	
	inspected or tested within the most recent twelve				compliance.		
	month period. Based on interview at the time of				Other Residents that have th	е	
	record review, the Maintenance Director stated				potential to be affected have		
	additional fire alarm testing documentation for the				been identified by:		
most recent twelve mor		month period was not			This deficit has the potential to	)	
	available for review	and stated the facility has one			affect over 2 staff and visitors.	The	
	elevator machine ro	om. Based on observations			shunt trip device location is ab	ole to	
	with the Administra	ator and the Maintenance			be identified and all heat dete	ctors	
	Director during a tour of the facility from				are inspected, with appropriate	е	
	p.m. to 2:10 p.m. on 10/11/23, the elevator machine				documentation present, to ens	sure	
	room in the basement is sprinklered. A shunt trip				in accordance to meet		
		located. Based on interview			compliance. Please see below	1	
	at the time of the observations, the Maintenance				measures implemented to pre	vent	
	Director stated a heat detector was installed in the		reoccurrence.				
	basement elevator machine room but did not know		The measures or systemic				
	the location of an elevator shunt trip device.			changes that have been put			
					into place to ensure that the		
	These findings were reviewed with the Administrator and the Maintenance Director				deficient practice does not		
					recur include:		
	during the exit conf	erence.			In-service completed with		
					maintenance director and		
	3.1-19(b)				administrator. Review initiated	l to	
				ensure that the elevator shunt	trip		

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

Event ID:

K1NP21 Facility ID: 000304

If continuation sheet Page 42 of 43

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/11/2023			
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			36 VAL	STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR  LAWRENCEBURG, IN 47025				
SHADY N  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION			and  Oure  ool lat do l			
				will be completed: 11/02/202	3			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: K1NP21 Facility ID: 000304 If continuation sheet Page 43 of 43