	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/13/2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 36 VILLAGE DRIVE LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG F 0000	(EACH DEFICIE	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	
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN0044 the allegations are Survey dates: Nov Facility number: 0 Provider number: AIM number: 1002 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type Medicare: 1 Medicaid: 65	ember 6, 7, 8, 12, and 13, 2024. 00304 155525 266810	F 0000			
F 0641 SS=D Bldg. 00	accordance with 4 Quality review cor 483.20(g) Accuracy of Asse Based on record refailed to ensure the assessments for 3 c (Residents 8, 91, a) Findings include:	essments view and interview, the facility accuracy of Minimum Data Set of 21 residents reviewed.	F 0641	By submitting the enclosed material, we are not admittin the truth or accuracy of any specific findings or allegation. We reserve the right to content the findings or allegations as	ns. est	
LIBORITOR	DIRLETORD ORTRO		5II OIL	IIIDD	(AO) DATE	

Lindsey Boltz Administrator 12/10/2024

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

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039			
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155525	B. WING		11/13/2024		
		1.000_0	<u> </u>		,		
NAME OF I	PROVIDER OR SUPPLIEF	8		T ADDRESS, CITY, STATE, ZIP COD			
TWINE OF I	THO VIDER OR SOLI EIEI		36 VILLAGE DRIVE				
SHADY I	NOOK CARE CENT	ΓER	LAWI	LAWRENCEBURG, IN 47025			
(V4) ID	CHMMADV	CTATEMENT OF DEFICIENCIE	ID ID		(V5)		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)		
PREFIX	·	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
				part of any proceedings and			
	1. The clinical reco	rd for Resident 8 was reviewed		submit these responses			
	on 11/13/24 at 1:15	P.M. A Quarterly Minimum		pursuant to our regulatory			
	Data Set (MDS) ass	sessment, dated 10/14/24,		obligations. The facility			
		ent was cognitively intact. The		requests that the plan of			
		tional Status" section of the		correction be considered ou	ır		
	_	ed the resident received		allegation of compliance			
	parenteral/intravenous feeding and had a feeding			effective 11-14-23 to the			
	tube while he was a resident in the facility during			Recertification and State			
	the assessment review period. The resident's						
				Licensure Survey completed	¹		
	physician's orders for October 2024 lacked an			on November 6, 7, 8, 12, 13			
	order for tube feedi	ing.		2024. We respectfully reque			
				paper review and will provid	e		
	_	v on 11/08/24 at 9:45 A.M., the		any additional information			
	resident indicated h	ne had never had a feeding		requested.			
	tube.						
				<u>F0641.</u>			
	During an interview	v on 11/13/24 at 1:36 P.M., the					
	MDS Coordinator i	indicated the resident didn't		It is the policy of this facility to	0		
	have a feeding tube	e. The Quarterly MDS		ensure accuracy of assessme			
	assessment was inc			with reflection of residents' sta			
	2 The clinical reco	ord for Resident 91 was reviewed		The corrective action taken	for		
		P.M. A Discharge MDS		those residents found to be			
		0/04/24, indicated the resident		affected by the deficient			
		gnitively impaired. The		practice includes:			
	1 -			practice includes.			
		tion of the assessment		Decidents C 04 07 b			
		ent discharged from the facility		Residents, 8, 91, 27 have no			
		ischarge was planned, and the		experienced negative outcom			
	resident went to a s	hort-term general hospital.		because of the alleged deficit			
				practice. Resident 8's MDS			
		v on 11/08/24 at 10:56 A.M., the		assessment was revised to re			
		ndicated the resident went to		that residents does not receiv	e		
	another Long Term	Care (LTC) facility.		parenteral/ intravenous feedir	ng and		
				does not have a feeding tube			
	A Nursing Note, da	ated 10/4/2024 at 12:00 P.M.,		Resident 91's MDS assessme			
		ent was discharging to another		revised to reflect that resident			
		nsported by the facility bus.		discharged to a nursing home			
				Resident 27's MDS assessme			

During an interview on 11/13/24 at 1:51 P.M., the

was revised to reflect that resident

12/11/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/13/2024 155525 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 36 VILLAGE DRIVE SHADY NOOK CARE CENTER LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE MDS Coordinator indicated the resident did not does not receive hospice services. go to the hospital he went to another LTC facility. The assessment should have accurately reflected Other Residents that have the the resident's discharge destination. potential to be affected have 3. The clinical record for Resident 27 was reviewed been identified by: on 11/13/24 at 2:02 P.M. A Quarterly MDS assessment, dated 08/22/24, indicated the resident Residents who have was moderately cognitively impaired. The assessments completed for resident's diagnoses included, but were not quality review have the potential to limited to, diabetes, hypertension, dementia, and be affected. Please see below for chronic obstructive pulmonary disease. Section O measures implemented to prevent "special treatments, procedures, and programs" reoccurrence. indicated the resident was receiving Hospice care while he was a resident in the facility during the The measures or systemic assessment review period. changes that have been put into place to ensure that the The August 2024 physician orders, provided by deficient practice does not the Director of Nursing (DON) on 11/14/24 at 2:15 recur include: P.M., lack documentation that the resident received Hospice care. MDS coordinator was educated on accuracy of MDS assessment. During an interview on 11/13/24 at 1:36 P.M., the MDS Coordinator indicated the resident didn't The corrective action taken to receive Hospice care. The Quarterly MDS monitor performance to assure assessment was incorrect and she referred to the compliance through quality RAI manual for completing MDS assessments. assurance: 3.1-31(c)(5)A performance improvement tool 3.1-31(c)(6)has been initiated that randomly 3.1-31(c)(8)audits five (5) residents to ensure that patients MDS assessment is accurately completed related to identification, swallowing and nutrition status and special treatments, procedures and programs. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee

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weekly x3 weeks, monthly for 3 months, then quarterly for 2

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155525	B. WING		11/13/2024	
NAME OF I	PROVIDER OR SUPPLIE	IR.		ADDRESS, CITY, STATE, ZIP COD		
				LAGE DRIVE		
SHADY	NOOK CARE CEN	IER	LAWRI	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		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				quarters. Any identified issues		
				be immediately addressed. The outcomes will be reviewed through		
				the facility Quality Assurance	ougn	
				Program. Monitoring will conti	nue	
				as planned or will be increase		
				the Quality Assurance Commi	ttee	
				if needed to obtain 100%		
				compliance. Additional action	will	
				be taken by the Quality		
				Assurance Committee if warra		
				based on the outcome of tools	5.	
				The date the systemic change	ges	
				will be completed: 11/14/202		
F 0684	483.25					
SS=D	Quality of Care					
Bldg. 00	Quality of Oale					
	Based on record re	eview and interview, the facility	F 0684	Tag F684 - Quality of Care	11/14/2024	
		ysician ordered vital signs prior		It is the facility policy to follow		
	to medication adm	inistration for 1 of 21 residents		physician's orders		
	reviewed for Quali	ity of Care. (Resident 1)		1: What corrective action(s) w	•	
				accomplished for those reside	l l	
	Findings include:			found to have been affected b	y the	
	TEL 11 1 1	IC D :1 /1		deficient practice?	.	
		I for Resident 1 was reviewed on		Residents 1 immediately had		
		.M. A Quarterly Minimum Data nent, dated 10/24/24, indicated		accounts audited by DON and		
		nent, dated 10/24/24, indicated oderately cognitively impaired.		reviewed vital signs with the medical director. Medical director	otor	
		moses included, but were not		and DON aligned vital sign	Stoi	
	_	nsion, diabetes, and dementia.		parameters with resident need	ds.	
	,,,					
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DEPARTMENT	Γ OF HEALTH AND HU!	MAN SERVICES				FO	RM APPROVED
CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155525	B. W	ING	· · · · · · · · · · · · · · · · · · ·	11/13	/2024
				CED FEET	ADDRESS CITY CTATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP COD		
OLIA DV	NOOK OADE OENT				LAGE DRIVE		
SHADY	NOOK CARE CENT	EK		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	REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)		DEFICIENCY)		DATE	
					Medical director and DON fou	nd	
	The Electronic Med	lication Administration			no adverse effects related to v	vital	
	Records (EMAR) for	or September and October 2024,			signs. Resident 1 had no nega		
		ne DON on 11/13/24 at 12:54			outcomes.		
		but were not limited to, the			2: How other residents having	the	
	following:	,			potential to be affected by the		
					same deficient practice will be		
	The September EM	AR indicated the resident			identified and what corrective		
	received the following medications:				action will be taken.		
		8			Residents with vital signs or he	old	
	- Lisinopril, for hyp	pertension, 20 milligrams (mg)			parameters have the potential		
	one time a day. Staff were to hold (not give) the				be effected.		
		sident's systolic blood			All current inhouse residents were		
		umber) was less than 100 or if			audited on 11/18/2024 by the		
		less than 60 beats per minute.			DON/Designee for vital signs	or	
		l a start date of 11/14/23.			hold parameters related to	O1	
					medication administration		
	The record had place	ces to document the resident's			.Medical Director reviewed an	v	
) and heart rate at 9:00 A.M.,			vital signs with DON and no	,	
		on was due to be administered.			adverse effects .		
		ents were left blank from			3: What measures will be put i	into	
		gh September 30, 2024.			place or what systemic change		
		,			will be made to ensure that the		
	- Propranolol, for h	ypertension, 10 mg two times a			deficient practice does not rec		
		nd 7:00 P.M. Staff were to hold			The DON educated licensed		
	_	e resident's systolic blood			nursing staff and QMA's on the	е	
		nan 100 or if their heart rate			policy titled "medication		
	_	ats per minute. The medication			administration".		
	had a start date of 0	-			4: How the corrective action w	ill be	
					monitored to ensure the defici		
	The record had place	ces to document the resident's			practice will not recur i.e., wha	nt	
		wo times a day, that were left			quality assurance program wil		
		month of September 2024.			put into place?		
		•			DON/designee will initiat a		
	The Vitals records t	for September 2024, were			preformance improvement too	l that	
		ON on 11/13/24 at 12:54 P.M.,			audits residents with vital sign		
					9		

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dates and times:

and indicated the resident's blood pressure and

heart rate were documented on the following

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hold parameters has been

completed timely and per

physician orders. This quality assurnace tool will be completed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155525	B. WING		11/13/2024
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF F	PROVIDER OR SUPPLIEF	₹		AGE DRIVE	
SHADY N	NOOK CARE CENT	TER		ENCEBURG, IN 47025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	- 09/01/24 at 7:10 A	A.M.,		weekly x3 weeks, monthly x 3	
	- 09/01/24 at 8:28 I			months then quarterly for 2	
	- 09/02/24 at 7:17 A			quarters. Any identified issues	
	- 09/03/24 at 12:20			be immediately addressed. Th	
	- 09/03/24 at 6:45 A			outcomes will be reviewed thr	ough
	- 09/04/24 at 11:46			the facility QA program.	
	- 09/05/24 at 11:03 P.M.,			Monitoring will continue as	
	- 09/10/24 at 7:31 A.M.,			planned or will be increased b	
	- 09/14/24 at 8:13 I	· ·		QA committee if needed to ob	tain
	- 09/19/24 at 11:42			100% compliance. Additional	
	- 09/24/24 at 11:06	P.M.		action will be taken by the QA	
				Committee if warranted based	l on
	_	s for September and October		outcome of tools.	
		d by the DON on 11/13/24 at		5. Date of completion: 11/14/2	2024
	_	ress Note, dated 09/10/24 at 8:30			
		resident's medications,			
	_	sinopril, had been held due to			
		rate of 56, which was below			
	_	The record lacked			
		ny refusals by the resident, or			
		s related to the prescribed			
	times the medication				
		Interdisciplinary Notes			
		ent had falls on 09/03/24 and			
		falls were documented in the			
	Progress Notes.				
	Neurological Evalu	ation Flow Records for the falls			
	_	/24/24 were provided by the			
		at 10:22 A.M. The records			
	indicated the reside	ent's blood pressure and heart			
		ted on the following dates and			
	times that were with	hin the two hour time frame the			
	medications were to	o be administered:			
	- 09/03/24 at 7:05 A	A.M.,			
	- 09/04/24 at 7:05 A				
	- 09/05/24 at 7:05 A				
	- 09/06/24 at 7:05 A				

- 09/24/24 at 7:15 P.M., and

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COME	E SURVEY PLETED 3/2024
	PROVIDER OR SUPPLIER		36 VILL	ADDRESS, CITY, STATE, ZIP COD .AGE DRIVE ENCEBURG, IN 47025	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING DIFFERMATION	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL DEFICIENCY)	LD BE	(X5) COMPLETION
TAG	from 09/25/24 throwwere documented to "AM", and in the extimes listed. The resident's clinic signs of BP or heart administration of Lithe following dates: 20, 21, 22, 23 and 3 The October EMAF received the following day. Staff were to he resident's systolic be 100 or if their heart minute. The medical 11/14/23. The record had place pressure and heart received the following day, at 9:00 A.M., at the medication if the pressure was less than 60 been had a start date of 0. The record had place pressure and heart received had place pressure was less than 60 been had a start date of 0.	isinopril and Propranolol for September 6, 7, 8, 9, 11, 12. 13, 0, 2024. R indicated the resident ing medications: Pertension, 20 mg one time a old the medication if the lood pressure was less than rate was less than rate was less than followed by the lood at a start date of the lood at the that were left blank from October 25, 2024. Pypertension, 10 mg two times a and 8:00 P.M. Staff were to hold are resident's systolic blood an 100 or if their heart rate at the perminute. The medication 1/17/22. Pers to document the blood at the twice a day, that were left 1, 2024, through the 9:00 A.M.	TAG	DEFICIENCY)	NOT THE PARTY OF T	DATE
	provided by the DO	For October 2024, were N on 11/13/24 at 12:54 P.M. It pressure and heart rate were				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155525	B. WI	NG		11/13	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	₹			AGE DRIVE		
SHADY N	NOOK CARE CENT	ER			NCEBURG, IN 47025		
			1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		CLSC IDENTIFYING INFORMATION	+	TAG	DETCHENC!)		DATE
	documented on the	following dates and times:					
	- 10/02/24 at 2:44 P	P.M.					
	- 10/02/24 at 2:44 I						
	from 10/26/24 through 10/31/24, the vital signs						
		wice a day, once in the					
	morning, and once in the evening.						
	morning, and once in the evening.						
	The resident's clinical record lacked any vitial						
	signs of BP or heart rate related to the						
	administration of Lisinopril and Propranolol for						
	the following dates: October 1 and October 3						
	through 24, 2024.						
	During an interview	v on 11/08/24 at 9:47 A.M., RN					
	4 indicated the facil	lity no longer used hard (paper)					
	charts.						
	_	v on 11/12/24 at 3:29 P.M., RN 4					
		a place on the EMAR for vital					
	_	d if a medication required a					
	_	ere to obtain the vital sign prior					
		n of the medication. There was					
		ld put on the EMAR as to why					
		held. Staff had to notify the					
	physician if the med	dication was neid.					
	The current "Admir	nistering Medications" policy,					
		of December 2012, was					
		ON on 11/13/24 at 10:45 A.M.					
		d, "Medications shall be					
		afe and timely manner, and as					
		lividual administering the					
	_	eck the label THREE (3) times					
		esident, right medication, right					
		and right method (route) of					
	administration before	- · · · · · · · · · · · · · · · · · · ·					
		nation must be checked/verified					
	for each resident pr						
	-	signs, if necessaryAs					
			1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COM			ETED
		155525	B. WI	NG		11/13/	2024
NAME OF I	DROWNER OR CURRY IER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER				AGE DRIVE		
SHADY	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NTE .	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	d for a medication, the ering the medication will record					
	in the resident's med	•					
	in the resident's med	ulcai record					
	3.1-37(a)						
F 0690	483.25(e)(1)-(3)						
SS=D		continence, Catheter, UTI					
Bldg. 00							
_	Based on observation	on, interview, and record	F 06	90	Tag F690 - Bowel/Bladder		11/14/2024
	review, the facility	failed to follow appropriate			Incontinence, Catheter, UTI		
	_	idelines related to indwelling			It is the facility policy to ensure	е	
	1	r a resident who had a Urinary			catheters are properly position	ned	
		1 of 2 residents reviewed for			1: What corrective action(s) w		
	urinary catheters. (F	Resident 7)			accomplished for those reside		
					found to have been affected b	y the	
	Findings include:				deficient practice?		
	Duning on absorvati	ion on 11/07/24 at 1.20 D.M.			Residents 7 immediately had infection control and the Difference of the Property of the design of the property of the design of the property of the design of the property of the propert		
	_	ion on 11/07/24 at 1:39 P.M., neir wheelchair in the main			infection control audited by D0 and reviewed all recent infecti		
		o six inches of their indwelling			with the medical director. Med		
	-	ing was laying on the floor			director and DON found no	licai	
	under their wheelch				adverse effects related to cath	neter	
					tubing noted to be touching th		
	During an observati	ion on 11/08/24 at 11:57 A.M.,			floor. The Medical Director an		
	_	neir wheelchair in the main			DON reviewed medical diagno		
	dining room eating	lunch, five to six inches of			and comorbidities related to		
	their indwelling uri	nary catheter tubing was laying			urinary tract infection.		
	on the floor under the	heir wheelchair.			2: How other residents having	j the	
					potential to be affected by the		
	_	ion on 11/08/24 at 2:56 P.M.,			same deficient practice will be	;	
		neir wheelchair in the main			identified and what corrective		
		ling herself, five to six inches			action will be taken		
		urinary catheter tubing was			current in-house residents w	ith	
	dragging on the floo	or under their wheelchair.			catheters were audited on		
		11.			11/18/2024 by the DON/Desig	·	
	_	ion and interview on 11/08/24			for infection control related to		
	at 2:58 P.M., the Director of Nursing (DON) indicated the indwelling urinary catheter tubing				indwelling catheters. The DON	v and	
					Medical director reviewed all		
	should not be touch	mg me noor.	1		I infections r/t UTI monthly and	1	

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

Event ID:

KEUK11 Facility ID: 000304

If continuation sheet Page 9 of 19

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155525	B. W	ING		11/13	/2024
				_	_		
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
01145)/	NOOK 0455 05N		36 VILLAGE DRIVE				
SHADY	NOOK CARE CENT	IER		LAWR	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED BY AN 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 APPROPR	BIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	KIA I E	DATE
					found no adverse effects r/t		
	During an interview	v on 11/08/24 at 3:30 P.M.,			infection control and indwelli	na	
	_	de (CNA) 2 indicated the			catheters on the floor.	9	
		g and tubing should not be			•		
	touch the floor.	5			3: What measures will be pu	t into	
					place or what systemic chan		
	The clinical record was reviewed on 11/08/24 at 3:00 P.M. A Quarterly Minimum Data Set (MDS)				will be made to ensure that t	-	
					deficient practice does not re		
	assessment, dated 10/21/24, indicated the resident was cognitively intact. The residents diagnoses included, but were not limited to, hypertension,				The DON educated all licens		
					nursing staff on the UTI and	ocu	
					indwelling catheter infection		
	renal insufficiency, obstructive uropathy (a condition where the flow of urine is blocked), and diabetes. The resident had an indwelling urinary				prevention policy and proced	lura	
					with concentration on, but no		
					limited to, catheter care and	λ.	
	catheter.	ent had an indwening urmary			prevention of infection.		
	catheter.				Education provided:		
	The November 202	24 Electronic Medication			Infection control of Cathete	r	
		cord (EMAR) indicated the			Care, Prevention of Catheter		
		eive Bactrim (an antibiotic)			Infection.		
		s (mg) 1 tablet every morning for			Notification of Provider rela	tod to	
		ection (UTI) for 7 days, with a			signs and symptoms of UTI.	ileu io	
	1	24, and Bactrim 400-80 mg 1			4: How the corrective action	will bo	
		g for a UTI for 7 days, with a			monitored to ensure the defi		
	start date of 11/08/2	-			practice will not recur i.e., wh		
	start date of 11/06/.	27.			quality assurance program w		
	The current "Cothe	ter Care, Urinary" policy, with			1	ill De	
		ecember 2007, was provided by			put into place? DON/designee will initiate a		
		1/13/24 at 10:48 A.M. The				al that	
		To prevent infection of the			performance improvement to audits residents with infection		
		ractBe sure the catheter					
		e bag are kept off the floor"			control for in dwelling cathete		
	tubing and drainage	e dag are kept off the noor			has been completed timely a	ıııu	
	2 1 41(a)(2)				per physician orders. This		
	3.1-41(a)(2)				quality assurance tool will be		
					completed weekly x3 weeks,		
					monthly x 3 months then qua	•	
					for 2 quarters. Any identified		
					issues will be immediately		
					addressed. The outcomes w	ill be	

reviewed through the facility QA program. Monitoring will continue

CENTERSTO	CMEDICALE & MEDIC	IND SERVICES			OMB 1(0: 0)00 (0)	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155525	B. WING		11/13/2024	
SHADY I	PROVIDER OR SUPPLIEF	ER	36 VILL LAWRE	ADDRESS, CITY, STATE, ZIP COD LAGE DRIVE ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				as planned or will be increase the QA committee if needed to obtain 100% compliance. Additional action will be taken the QA Committee if warrante based on outcome of tools. 5. Date of completion: 11/14/2	by d	
F 0757 SS=D Bldg. 00	Drugs	Free from Unnecessary				
	failed to follow the hold parameters for residents reviewed (Resident 72) Findings include: The clinical record on 11/07/24 at 1:28 Data Set (MDS) assindicated the reside impaired. The reside were not limited to, ventricular fibrillatineart muscle). The Electronic Med Records (EMAR) for were provided by the on 11/13/24 at 10:4 the resident had the order:	physician's orders related to a medication for 1 of 5 for unnecessary medications. for Resident 72 was reviewed P.M. A Quarterly Minimum sessment, dated 09/18/24, and was severely cognitively tent's diagnoses included, but Parkinson's disease and ton (irregular contraction of the dication Administration for October and November 2024, the Director of Nursing (DON) of A.M. The records indicated of following current physician's a medication (mg), give 12.5 mg by	F 0757	Tag F757 - Drug Regimen is f from unnecessary drugs It is the policy of this facility to follow physician orders 1: What corrective action(s) w accomplished for those reside found to have been affected b deficient practice? • Residents 72 immediately had accounts audited by DON and reviewed all missed physician orders for holding medication the medical director. Medical director and DON aligned vital hold parameters with resident needs at this time. Medical director and DON found no adverse effects related to missivital signs. 2: How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All current inhouse residents	ill be ents y the ad I with I sign	
	fibrillation. The me given) if the resider	day related to ventricular dication was to be held (not nt's heart rate was less than 60 he start date for the medication		were audited on 11/18/2024 b DON/Designee forvital signs of hold parameters related to medication administration	- I	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155525	B. W	ING		11/13/	/2024
			<u> </u>	CTREET	ADDRESS SITU STATE TO SOF		
NAME OF F	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
					AGE DRIVE		
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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	was 10/04/24.				.Medical Director reviewed vita	al	
					signs with DON and no advers	se	
	The record indicate	d the medication had been			effects were noted nor vital sig	gns/	
	administered outsid	e of the ordered parameters,			hold parameters were missed		
	when the resident's	heart rate was less than 60			3: What measures will be put	into	
	beats per minute, or	n the following dates and			place or what systemic change	es	
	times:				will be made to ensure that the	е	
					deficient practice does not rec	ur?	
	- 10/06/24, at 9:00 A	A.M., the heart rate was 42,			The DON educated all license	d	
	- 10/06/24, at 9:00 l	P.M., the heart rate was 56,			nursing staff on the medication	n	
	- 10/11/24, at 9:00 A	A.M., the heart rate was 49,			administration policy and		
	- 10/14/24, at 9:00 A.M., the heart rate was 52,				procedure with concentration	on,	
	- 10/19/24, at 9:00 A.M., the heart rate was 48,				but not limited to, vital signs a	nd	
	- 11/02/24, at 9:00 A	A.M., the heart rate was 46,			hold parameters.		
	- 11/02/24, at 9:00 l	P.M., the heart rate was 57,			Education provided:		
	- 11/03/24, at 9:00 A	A.M., the heart rate was 58, and			Medication Administration		
	- 11/07/24, at 9:00 l	P.M., the heart rate was 51.			 Notification of Provider for ar 	ny	
					vital signs that are out of		
	During an interview	on 11/08/24 at 9:47 A.M., RN			parameter setting.		
	4 indicated the facil	ity no longer used hard (paper)			4: How the corrective action w	ill be	
	charts.				monitored to ensure the defici	ent	
					practice will not recur i.e., wha	nt	
	_	on 11/12/24 at 3:29 P.M., RN 4			quality assurance programs w	ill be	
		a place on the EMAR for vital			put into place?		
	_	l if a medication required a			DON/designee will initiate a		
	_	re to obtain the vital sign prior			performance improvement too		
		n of the medication. There was			audits residents with vital sign	s or	
		ld put on the EMAR as to why			hold parameters has been		
		held. Staff had to notify the			completed timely and per		
	physician if the med	dication was held.			physician orders. This quality		
					assurance tool will be complet		
		nistering Medications" policy,			weekly x3 weeks, monthly x 3		
		of December 2012, was			months then quarterly for 2		
	l - ·	ON on 11/13/24 at 10:45 A.M.			quarters. Any identified issues		
		d, "Medications shall be			be immediately addressed. Th		
		afe and timely manner, and as			outcomes will be reviewed three	ough	
	1 -	lividual administering the			the facility QA program.		
		eck the label THREE (3) times			Monitoring will continue as		
		esident, right medication, right			planned or will be increased b	-	
	dosage, right time a	nd right method (route) of			QA committee if needed to ob	tain	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETE			
		155525	B. Wl	NG		11/13/2024	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 36 VILLAGE DRIVE LAWRENCEBURG, IN 47025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	for each resident pri	ation must be checked/verified			100% compliance. Additional action will be taken by the QA Committee if warranted based outcome of tools. 5. Date of completion: 11/14/2	l on	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs						
	failed to appropriate medication carts rev Cart 1, C Street Me Medication Cart 1) Findings include: 1. On 11/12/24 at 9: Cart 1 was observed following: - A small round yell green pill were lying second drawer, and - A small round white bottom of the third of the cart 2 was observed following: - One small round wround white pill were following: - One small round wround white pill were the second drawer. 3. On 11/12/24 at 10 observed removing	ite pill was lying loose in the	F 07	761	Tag F761 - Label/Store Drugs Biologicals "It is the facility policy to follow medication storage policy." 1: What corrective action(s) w accomplished for those reside found to have been affected by deficient practice? • Residents immediately had accounts audited by DON and reviewed all medications store medication carts with the med director. Medical director and aligned medication administra with resident needs at this tim Medical director and DON fou no adverse effects related to medication storage. 2: How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All current inhouse residents were audited on 11/18/2024 b DON/Designee for medication administration and medication storage in medication carts .Medical Director reviewed all medication storage with DON	ill be ints y the d in ical DON tion e. nd the	11/14/2024

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
155525		155525				11/13/	2024	
			<u> </u>	CENTRE	ADDRESS CITY OF THE CON-			
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD			
			36 VILLAGE DRIVE					
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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	second drawer of th	e B Street Medication Cart 1.			no adverse effects were noted	l.		
	The pills were loose	e and not in a secured			3: What measures will be put i	into		
	medication sheet.				place or what systemic change	es		
					will be made to ensure that the	е		
	During an interview	v on 11/12/24 at 10:26 A.M., the			deficient practice does not rec	ur?		
	Director of Nursing	(DON) indicated loose pills			The DON educated all license	d		
		in the bottom of the			nursing staff on the medication	n		
	medication carts. S	the was unaware of which			storage policy and procedure	with		
	residents the loose i	medications would have	1		concentration on, but not limite	ed		
	belong too.				to, proper storage, medication			
					expiration dates.			
	The current undated	l facility policy, titled			Education provided:			
	"MEDICATION ST	TORAGE IN THE FACILITY",			Medication storage			
	was provided by the	e DON on 11/13/24 at 10:23			 Medication Cart cleanliness, 			
	A.M. The policy in	dicated, "Medications and			expiration dates for medication	n.		
	biologicals are store	ed safely, securely, and			4: How the corrective action w	ill be		
	properly, following	manufacturer's			monitored to ensure the defici-	ent		
	recommendations o	r those of the supplier"			practice will not recur i.e., wha	ıt		
					quality assurance program wil	l be		
	3.1-25(o)				put into place?			
					DON/designee will initiate a			
					performance improvement too	l that		
					audits residents with medication	on		
					storage has been completed			
					timely and per physician order			
					This quality assurance tool wil	l be		
					completed weekly x3 weeks,			
					monthly x 3 months then quar	terly		
					for 2 quarters. Any identified			
					issues will be immediately			
			1		addressed. The outcomes will			
					reviewed through the facility C			
					program. Monitoring will contin			
			1		as planned or will be increase	-		
					the QA committee if needed to)		
					obtain 100% compliance.			
			1		Additional action will be taken	-		
					the QA Committee if warrante	d		
					based on outcome of tools.			
				5. Date of completion: 11/14/2	024			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED			
155525		B. W	B. WING 11/13/2024			/2024			
N	NOVEDED OF STATE			STREET .	ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIER			36 VILLAGE DRIVE					
SHADY NOOK CARE CENTER				LAWRE	ENCEBURG, IN 47025				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)		
PREFIX		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
F 0812	483.60(i)(1)(2)								
SS=F	Food								
Bldg. 00		e/Prepare/Serve-Sanitary							
		on, interview, and record	F 0	812	By submitting the enclosed		11/14/2024		
		failed to prepare and store			material, we are not admitting				
		nanner for 2 of 2 kitchen			truth or accuracy of any speci				
		iled to maintain resident snack			findings or allegations. We re-				
	_	nitary manner related to the			the right to contest the finding	s or			
		items and outdate foods for 3			allegations as part of any				
		tors observed. This deficient			proceedings and submit these)			
	1 -	ential to affect on 82 of 82			responses pursuant to our				
		ve food from the kitchen or			regulatory obligations. The facility				
	snack refrigerators.				requests that the plan of correction be considered our allegation of compliance effective 11-14-23 to the Recertification and				
	Findings include:								
	_	kitchen tour on 11/06/24 at			State Licensure Survey completed on November 6, 7, 8, 12, 13 2024. We respectfully request a paper review and will provide any additional information requested. F812. It is the policy of this facility to				
		e Dietary Manager (DM), the							
	following was obser	rved:							
		om floor was littered with							
		, a package of crackers; a line							
	_	ne and a half inches wide by							
	two feet long running along the wall behind a wire rack of shelves; bits of white paper and straw; a				store, prepare, distribute and				
					food in accordance with curre				
	large plastic bag, open to air, of white powder was sitting inside of an open cardboard box; and there was a large silver scoop laying in the bag on top of the powder. The DM indicated the white				standards for food service saf	-			
					The corrective action taken fo	r			
					those residents found to be affected by the deficient practice				
	_	ickener and a scoop should			includes:				
	not have been left in	n the bag with the thickener.			There have been no negative				
					outcomes because of this alle	•			
		inverted and covering plates			deficit practice. The facility dry	/			
		had a brown/yellow sticky			storage room and all kitchen				
	residue in the edges	of the bowls,			flooring is clean and in compli				
	m 11 1 1 1	1 / 21/1 1 1			with current standards for foo				
		d carts, with three shelves,			service safety. Food thickener is				
		ered with crumbs. One cart held			in a storage container without				
	I -	ne dessert, and one cart held			scoop. Two silver bowls cover	•			
stacks of clean trays to be used for the meal		1		I plate warmer are clean and in	ı	I			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED			
		155525	B. WI			11/13/			
				CENTER	A DDDEGG CVIIV CT A THE TID COD				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD				
SHADY NOOK CARE CENTER				36 VILLAGE DRIVE LAWRENCEBURG, IN 47025					
SHADYI	NOOK CARE CENT	ER		LAWKE	ENCEBURG, IN 47025				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE		
	service,				compliance with current stand				
					for food service safety. All bla				
		of three food preparation			wheeled carts are clean and in				
		with crumbs and crumbs along			compliance with current stand	lards			
	the floor under then	n,			for food service safety. Food				
					preparation tables are clean a				
		nit holding the juice machine			compliance with current stance	lards			
		ix inch by two inch,			for food service safety. Metal				
		uses attached to the back of			shelving holding the juice made	chine			
		overed in gray dust as were the			clean and in compliance with				
	wires on the rack, a	nd			current standards for food ser	vice			
					safety. Small shelf under the				
		s of debris, one inch by two			steam table clean, with no pre				
	_	ere noted by the wall under			paper clips and in compliance				
		r the door to the main dining			current standards for food ser	vice			
	room.				safety. Residents' snack				
	m 1 1 1 1 1 1				refrigerators hold no ice packs	s or			
	_	ule for the week was posted			cold therapy. Resident snack				
		itchen and was provided by the			refrigerator for D- street conta				
		11:41 A.M. The DM indicated			no plastic grocery bag labeled	1,			
		he area on the cleaning			"Pam C." A regular cleaning				
	· ·	had completed the tasks on			schedule was updated for				
		opened a drawer in her office			systemic changes.				
		ral older cleaning schedules,			Other Residents that have the	=			
		e cleaning schedule for the			potential to be affected have be	been			
		nough 11/09/24 indicated no			identified by:	la ha			
		completed since day shift on			Residents have the potential taffected by the alleged deficit				
	_	Cleaning tasks to be completed							
		evening shift staff members			practice. Please see below fo measures implemented to pre				
	, ,	•			reoccurrence.	veni			
	were listed for each day of the week. 2. During the second tour of the kitchen on 11/12/24 at 11:05 A.M., the following was				The measures or systemic				
					changes that have been put in	nto			
					place to ensure that the defici				
	observed:	, 			practice does not recur includ				
	23301,04.				All kitchen staff in-serviced or				
	- The metal shelf ur	nit holding the juice machine			updated cleaning checklist	•			
		ix inch by two inch,			labeled, "Deep Clean Checklist	st "			
		uses attached to the back of			Educated on policies for, "Uni				
		overed in gray dust as were the			Kitchenettes and Pantries",	-			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. Building <u>00</u>		COMPLETED		
		155525	B. W	ING		11/13/	11/13/2024	
				CTREET	ADDRESS SITY STATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
				36 VILLAGE DRIVE				
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	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	16	DATE	
	wires on the rack,				"Foods brought by Family/Visi	tors"		
					and "Cleaning and Sanitation			
	- One black wheele	d cart with three shelves had			Food Service Areas." Dietary			
		s littered with crumbs. The top			manager educated on maintai	nina		
		eart held stacks of clean trays			kitchen according to food serv	_		
	to be used for reside	_			safety.			
					The corrective action taken to			
	- Two silver bowls	inverted to cover the top of			monitor performance to assure	2		
	· ·	he plate warmer, had a			compliance through quality			
	_	ue in the edges of the bowls,			assurance:			
	and	and the tages of the courts,			A performance improvement to	ool		
	una				has been initiated that audits t			
	- A small shelf und	er the steam table contained			kitchen and maintains current	i i C		
		I sized plastic lids sitting with			standards for food service safe	atı (
		ps. A nearby cup held several			A Quality Assurance Audit Too	-		
	paperclips.	ps. A hearby cup hera several			<u> </u>	וכ		
	paperemps.				will be completed by the food			
	2 Pagidantal angala	refrigerators were observed on			service director daily x3 weeks			
		A.M., with the Assistant Director			weekly X3 weeks, monthly for	3		
					months, then quarterly for 2			
	of Nursing (ADON), and contained the following:			quarters. Any identified issues			
	TI C.C. , C.	4 1 0 11			be immediately addressed. Th			
		gerator contained a soft sided			outcomes will be reviewed thro	ougn		
		ack in the freezer that had no			the facility Quality Assurance			
		marks. The pack was			Program. Monitoring will conting			
		nches by 12 inches in size. The			as planned or will be increased	-		
		had been in there for at least as			the Quality Assurance Commi	ttee		
		emember, but did not know			if needed to obtain 100%			
		for. The soft covered ice pack			compliance. Additional action	will		
	was labeled "Cold "	Гherapy", and			be taken by the Quality			
					Assurance Committee if warra			
	- The resident snack refrigerator used for "A" and "B" Streets contained a plastic bag of small cups of ice cream in the freezer that were leaning against a large soft covered ice pack, labeled "Cold Therapy". The pack was approximately 12				based on the outcome of tools			
					The date the systemic change			
					will be completed: 11/14/2024			
	inches by 12 inches	s in size.						
		ck refrigerator for D-Street was						
	observed on 11/13/2	24 at 11:42 A.M., with Licensed						
	Practical Nurse (LP	(N) 6, and contained the						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 00 COMPLETED				
		155525	B. W	'ING		11/13	/2024
NAME OF P	DOMDED OF CURPUSE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C			AGE DRIVE		
	NOOK CARE CENT	ER		LAWRE	NCEBURG, IN 47025		
(X4) ID		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	following:	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	ionowing.						
	- A gray plastic gro	cery bag, labeled "Pam C.",					
		wl of coleslaw with a lid, dated					
	08/02/24, a small pa	aper sack containing onion					
		oon, and a sandwich box with					
		LPN 6 indicated residents' items					
		en put in the refrigerator and					
	disposed of after 48	s hours.					
	During an interview	on 11/13/24 at 11:50 A.M., the					
	_	ne did not know what the					
		related to having cold therapy					
		idents' snack refrigerators.					
	-	v on 11/13/24 at 2:09 P.M., the					
		ndicated they stored ice packs					
		r therapy gym. The Nursing					
	-	ode to enter the Therapy Gym					
	-	. The therapy staff did not acks in the resident snack					
		ce packs were soft sided and					
	blue in color.	te packs were soft sided and					
	During an interview	on 11/13/24 at 2:21 PM., the					
	ADON indicated al	l of the residents in the					
	building received for	ood from the facility kitchen.					
	The undated "Cleaning Schedule" policy was provided by the Administrator on 11/13/24 at 1:46 P.M. The record indicated, "All small equipmentappliancescountersdishesDelive						
		be cleaned after each use.					
	The current "Unit Kitchenettes and Pantries" policy, with a reviewed date of 07/2023, was						
	-	ministrator on 11/13/24 at 1:46					
		licated, "The food service					
	manager willremo	ove outdated items"					

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

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	lì í		NSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	00	COMPL		
155525		B. W	ING		11/13	/2024		
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 36 VILLAGE DRIVE LAWRENCEBURG, IN 47025					
	THE PROPERTY OF THE SERVICE OF THE S				,			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		PRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Brought by Family/Visitors"						
	*	ed date of October 2017, was						
		the Entrance Conference. The						
		Food broughtthat is left with						
		ume later will be labeled and						
		that is clearly distinguishable						
	* * *	red foodPerishable foods						
		e-sealable containers with						
		n a refrigerator. Containers will						
		resident's name, the item and						
	-	The nursing and/or food						
	service staff will dis	scard any foodsthat show						
	obvious signs of po	tential food borne dangerfor						
	examplemoldpa	st due package expiration						
	dates"							
	Service Areas" poli 07/2023, was provid 11/13/24 at 1:46 P.I food service staff with thefood service ar writen [sic], compre cleaning schedule was schedule was serviced at the compression of the compr	ing and Sanitation of Food cy, with a reviewed date of ded by the Administrator on M. The policy indicated, "The vill maintain the sanitation of reas through compliance with a ehensive cleaning scheduleA vill be posted for all cleaning						
	tasksStaff will be assignments"	held accountable for cleaning						
	3.1-21(i)(3)							

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