STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155525	B. WING	_	12/05/2024	
			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8		AGE DRIVE		
SHADY I	NOOK CARE CENT	ER		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	
E 0000						
<b>.</b>						
Bldg		1 0	F 0000			
		paredness Survey was	E 0000			
		ndiana Department of Health in				
	accordance with 42	CFR 483./3.				
	Survey Date: 12/05	5/24				
	Survey Date: 12/03	<i>11                                   </i>				
	Facility Number: 0	000304				
	Provider Number:					
	AIM Number: 100					
		200010				
	At this Life Safety	Code survey, Shady Nook Care				
	Center was found in compliance with Emergency					
		irements for Medicare and				
		ting Providers and Suppliers, 42				
	CFR 483.73.					
	The facility has 94	certified beds. At the time of				
	the survey, the cens	sus was 85.				
	Quality Review cor	npleted on 12/09/24				
K 0000						
11.0000						
Bldg. 01						
	A Life Safety Code	Recertification and State	K 0000			
		vas conducted by the Indiana	1.0000			
		lth in accordance with 42 CFR				
	483.90(a).					
	Survey Date: 12/05	5/24				
	Facility Number: 0	000304				
	Provider Number:	155525				
	AIM Number: 100	266810				
		Code survey, Shady Nook Care				
	Center was found n	ot in compliance with				
	<u>I</u>		<u> </u>	I		
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	
Lindsev			Boltz		12/26/2024	

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 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 12/05/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  36 VILLAGE DRIVE LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0214	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of the National Fire Protect Life Safety Code (L Health Care Occupation of the Safety Code (L Health Care Occupation of the Safety Sa	the ty of 94 and had a census of survey.  determined by the control of the contro				
K 0211 SS=E Bldg. 01	failed to ensure 1 of the Memory Care H maintained free of a to full instant use in emergency. This do residents and staff in Findings include: Based on observation Maintenance Direct facility from 1:45 p	ation and interview, the facility I corridor means of egress on all was continuously Ill obstructions or impediments the case of fire or other efficient practice affects 26 In the facility.  In the facility.  In the facility one and interview with the corror (MD) during a tour of the corror (MD) during a tour of the corror (MD) processes the facility of the corror (MD) during a tour of the corror (MD) processes the facility of the corror (MD) during a tour of the corror (MD) during a tour of the corror (MD) processes the facility of the corror (MD) during a tour of the corror (MD) during	K 0211	Section 1: By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We rest the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect	fic serve s or cility	
	the Memory Care H was in use, occupied	all a large blue reclining chair d by a resident, and		12/25/2024 for the Emergency Preparedness survey date	y	

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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 <u>01</u>			COMPL	ETED
		155525	B. W	B. WING 12/05/			2024
			<u> </u>	CERTE	ADDRESS STEW STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
OLIA DVA	JOOK OADE OENT				AGE DRIVE		
SHADY	NOOK CARE CENT	EK		LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENCE N. AN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		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
	positioned near the	exit door, obstructing the exit.			12/05/24 and for the Life and		
	Based on an intervi	ew at the time of observations,			Safety recertification and state		
	the MD stated the c	hair is usually not in the			licensure survey conducted or	1	
	corridor obstructing	g the exit door.			12/05/24. We respectfully requ	ıest	
					a paper review and will provide	e any	
	3.1-19(b)				additional information requeste	ed.	
					K211		
	2) Based on observa	ation and interview, the facility			It is the practice of this facility	to	
	failed to ensure 1 of	f over 4 exit discharges had a			ensure that all means of egres	s	
	level walking surface	ce, was free of obstructions or			are maintained in accordance	with	
	impediments for full instant use in the case of fire				NFPA 101: LSC chapter 7,		
	or other emergency	. This deficient practice could			ensuring that they remain clea	r of	
	affect 15 residents a	and staff.			obstacles.		
					The corrective action taken for		
	Findings include:				those residents found to be		
					affected by the deficient practi	ce	
	Based on observation	ons and interview with the			include:		
	Maintenance Direct	tor (MD) during a tour of the			It is the policy of this facility to		
	facility from 1:45 p	.m. to 4:15 p.m. on 12/05/24, the			ensure that all means of egress		
	exit discharge near	the Hair Care had two large			are maintained and free of		
	mats on the landing	g. The Administrator stated			obstacles. The emergency exi	t on	
	staff stand on the m	nats in the salon and someone			the west end of the memory ca	are	
		itside to clean and forgot to			hall is free of obstacles and is		
		re they were used. The large			maintained to allow movemen	t to	
		the landing outside the exit			emergency exit. 7 of 7 corridor	rs	
	door created an obs	truction leading to the			meet this standard.		
	common way.				Other Residents that have the		
					potential to be affected have b	een	
	_	knowledged by the MD at the			identified by:		
	1	and again at the exit			This deficit has the potential to		
		MD and Administrator			affect staff, residents, and visit	tors.	
	present.				All emergency corridors were		
					reviewed and assessed to ens	ure	
	3.1-19(b)				in accordance to meet		
					compliance. Please see below		
					measures implemented to pre	vent	
					reoccurrence.		
					The measures or systemic		
					changes that have been put in		
					place to ensure that the deficie	ent	

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/05/2024
	ROVIDER OR SUPPLIE		36 VILL	ADDRESS, CITY, STATE, ZIP COD LAGE DRIVE 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TON (X5) D BE COMPLETION OPRIATE DATE
				practice does not recur ind In-service completed with maintenance director and administrator. All staff in-scompleted re: maintaining emergency corridors; free obstructions. Review initial ensure that emergency coshall maintain compliance meet regulations. This will discussed as part of operamorning and afternoon meter the corrective action take monitor performance to ascompliance through quality assurance:  A performance improvement has been initiated that obscorridors and maintains compliance related to life asafety. A Quality Assurance Tool will be completed by maintenance director or didaily x3 weeks, weekly x3 monthly for 3 months, ther quarterly for 2 quarters. An identified issues will be immediately addressed. Toutcomes will be reviewed the facility Quality Assurance Program. Monitoring and education will continue as or will be increased by the Assurance Committee if nobtain 100% compliance. Additional action will be tathe Quality Assurance Coif warranted based on the of tools.  The date the systemic characteristics.	of sted to pridors and libe ational settings. In to source by sent tool serves and see Audit the sesignee so weeks, in my libe at through ince planned so Quality seeded to liken by mmittee outcome

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 12/05/2024	
	ROVIDER OR SUPPLIEI		36 VILL	ADDRESS, CITY, STATE, ZIP COD LAGE DRIVE ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				will be completed: 12/25/24 Section 2: By submitting the enclosed material, we are not admitting truth or accuracy of any speci findings or allegations. We resthe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect 12/25/2024 for the Emergency Preparedness survey date 12/05/24 and for the Life and Safety recertification and state licensure survey conducted of 12/05/24. We respectfully requipapper review and will provide additional information request K211 It is the practice of this facility ensure that all means of egresare maintained in accordance NFPA 101: LSC chapter 7, ensuring that they have a level walking surface. The corrective action taken for those residents found to be affected by the deficient practiculude: It is the policy of this facility to ensure that all means of egresare maintained and are of level surface. The emergency exit in the hair salon is free of obstace and is maintained level to allow movement through emergency.	fic serve so or serve se

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	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 COMPL 12/05/	ETED
	ROVIDER OR SUPPLIE		36 VILI	ADDRESS, CITY, STATE, ZIP C LAGE DRIVE 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 COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE
				exit. 7 of 7 exits meet to standard.  Other Residents that he potential to be affected identified by:  This deficit has the potential to get affect staff, residents, and assessed to ensure accordance to meet concordance to ensure that the practice does not recurred in-service completed with all staff compliance in maintain level at means of egresinitiated to ensure that exits shall maintain concordant meet regulations. It discussed as part of opmorning and afternoon the corrective action to monitor performance to compliance through quassurance:  A performance improve has been initiated that means of egress and in current compliance for level at each means of Quality Assurance Aud be completed by the midirector or designee data.	ave the I have been ential to and visitors. Ere reviewed e in empliance, sures at emic en put into e deficient include: with and ee to ensure aing surface ess. Review emergency empliance This will be be be perational entings. Eaken to ensure ality ement tool audits all maintains surface egress. A lit Tool will aintenance	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155525		A. BUILDING 01  B. WING		COMPLETED  12/05/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  36 VILLAGE DRIVE LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
K 0353 SS=E	NFPA 101	· Maintenance and Testing		weeks, weekly X3 weeks, mor for 3 months, then quarterly fo quarters. Any identified issues be immediately addressed. Th outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continus planned or will be increased the Quality Assurance Commit if needed to obtain 100% compliance. Additional action obe taken by the Quality Assurance Committee if warra based on the outcome of tools The date the systemic change will be completed: 12/25/24	r 2 will e bugh nue d by ttee will nted		
Bldg. 01	failed to maintain the the dryers. The ceilia around the sprinkler operate at a specific edition, 8.5.4.1.1 stasprinkler deflector a selected based on the type of construction could affect 3 laund. Findings include:  Based on observation Maintenance Direct facility from 1:45 p. behind the dryer the sprinkler head may	tion and interview, the facility be ceiling construction behind ing traps hot air and gases and cause the sprinkler to differ the distance between the indifference of the test the distance between the indifference of sprinkler and the eight of sprinkler and the indifference of the indi	K 0353	By submitting the enclosed material, we are not admitting truth or accuracy of any specif findings or allegations. We resthe right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect 12/09/2024 for the Emergency Preparedness survey date 12/05/24 and for the Life and Safety recertification and state licensure survey conducted on	ic erve s or ility		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPL	COMPLETED	
		155525	B. W	ING		12/05/	/2024	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹			AGE DRIVE			
SHVDA V	NOOK CARE CENT	ED			ENCEBURG, IN 47025			
SHADIT	NOOK OAKE CENT	LIX		LAWKE				
(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 AC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		r head was once located. The			12/05/24. We respectfully requ	uest		
		sprinkler head had been			a paper review and will provid	e any		
	removed and stated	he would investigate.			additional information request	ed.		
					K353			
	-	viewed with the Maintenance			It is the practice of this facility	to		
		nistrator during the exit			ensure that sprinkler heads ar	е		
	conference				maintained in accordance with	1		
					NFPA 101: LSC chapter 9,			
	2. Based on observation and interview, the facility				ensuring that they are installed			
		f 1 sprinkler heads in the			with no gaps allowing moveme	ent of		
	-	not loaded or covered with			heat.			
	~	accordance with LSC 9.7.5.			The corrective action taken for	r		
		tion, at 5.2.1.1.1 sprinklers shall			those residents found to be			
	-	eakage; shall be free of			affected by the deficient practi	ce		
	_	naterials, paint, and physical			include:			
	-	be installed in the correct			It is the policy of this facility to			
		-right, pendent, or sidewall).		ensure that sprinkler heads are				
		.1.1.2 any sprinkler that shows			maintained. The sprinkler hea			
		following shall be replaced: (1)			behind the dryers in laundry ro			
		ion (3) Physical Damage (4)			is installed correctly and ceilin	-		
		glass bulb heat responsive			around head is maintained into	act.		
		g (6) Painting unless painted by			All sprinklers heads meet this			
	-	acturer. This deficient practice			standard, no residents were fo			
	could affect 3 laund	lry staff.			to be affected by the potential			
	TO 11 1 1 1				deficit practice.			
	Findings include:				Other Residents that have the			
	n 1 1	in a second			potential to be affected have b	een		
		ons and interview with the			identified by:			
		tor (MD) during a tour of the			This deficit has the potential to	)		
		.m. to 4:15 p.m. on 12/05/24, 1 of			affect staff and residents. All			
	-	chind the dryers in the laundry			sprinkler heads reviewed and			
		n dust or showed signs of			assessed to ensure in accorda			
	loading.				to meet compliance. Please so			
	This finding was	viewed with the Meintenen			below measures implemented	ιο		
		viewed with the Maintenance			prevent reoccurrence.			
		nistrator during the exit			The measures or systemic			
	conference.				changes that have been put in			
	2.1.10/5				place to ensure that the deficie			
	3.1-19(b)				practice does not recur include	e:		
l l			1		In-service completed with		I	

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/05/2024		
	ROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD  36 VILLAGE DRIVE 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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION (X5) D BE COMPLETION OPRIATE DATE		
				maintenance director, housekeeping director and administrator re: Sprinkler maintenance. Review initial ensure that sprinkler head maintain compliance and regulations. This will be disas part of operational more afternoon meetings. The corrective action taken monitor performance to as compliance through quality assurance:  A performance improvement has been initiated that audity sprinkler heads and maintacurrent standards for sprinkler heads and maintacurrent standards for sprinkler director/designee daily x3 weekly X3 weeks, monthly months, then quarterly for quarters. Any identified issue immediately addressed outcomes will be reviewed the facility Quality Assurance Corif needed to obtain 100% compliance. Additional act be taken by the Quality Assurance Corif needed to obtain 100% compliance. Additional act be taken by the Quality Assurance Committee if we based on the outcome of the Completed: 12/09/2 Section 2:  By submitting the enclosed material, we are not admittruth or accuracy of any sprinkler heads and maintain truth or accuracy of any sprinkler heads in the substance of the completed: 12/09/2 Section 2:  By submitting the enclosed material, we are not admittruth or accuracy of any sprinkler heads and maintain truth or accuracy of any sprinkler heads in the substance of the completed: 12/09/2 Section 2:	thead tated to tals shall meet scussed ning and on to ssure y  ent tool dits tains nklers. A fool will tenance weeks, y for 3 2 sues will d. The d through nce continue tenased by mmittee tion will varranted tools. tanges ted d d d d d d d d d d d d d d d d d d		

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION DESTRICT ADDRESS. CITY, STATE, ZIP COD 3 STRUCT ADDRESS. CITY, STATE, ZIP COD 3 STATE ADDRESS. CITY, STATE, ZIP COD 3 STATET A	CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
NAME OF PROVIDER OR SUPFLIER  SHADY NOOK CARE CENTER  SHULAGE DRIVE LAWRENCEBURG, IN 47025  (CACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  REGULATORY OR LARGE THE AND A TORRETTENCE INFORMATION  TAG  REGULATORY OR LARGE THE AND A TORRETTENCE INFORMATION  TAG  REGULATORY OR LARGE THE AND A TORRETTENCE INFORMATION  TAG  REGULATORY OR LARGE THE AND A TORRETTENCE INFORMATION  TAG  REGULATORY OR LARGE THE AND A TORRETTENCE INFORMATION  TAG  REGULATORY OR LARGE THE AND A TORRETTENCE  REGULATORY OR L	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  SHADY NOOK CARE CENTER  DESIGNATE OF DEFICIENCE PREEX (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  TAG  TAG  SUMMARY STATEMENT OF DEFICIENCE PREEX (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  TAG  TAG  TAG  TAG  TAG  TAG  TA	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPI	LETED
SHADY NOOK CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG REGULATORY SUBJECTION  TAG REGULATORY SUBJEC			155525	B. WING		12/05	/2024
SHADY NOOK CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG REGULATORY SUBJECTION  TAG REGULATORY SUBJEC				STREET	ADDRESS, CITY, STATE, ZIP COD		
CAS   ID   PREFIX   GEACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTI	NAME OF P	ROVIDER OR SUPPLIEF	8				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG Indings 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 12/09/2024 for the Emergency Preparedness survey date 12/05/24 and for the Life and Safety recertification and state licensure survey conducted on 12/05/24. We respectfully request a paper review and will provide any additional information requested. K333  It is the practice of this facility to ensure that sprinkler heads are maintained in accordance with NFPA 101: LSC chapter 9, ensuring that they are clean and clear of foreign materials. 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 sprinkler heads are maintained. The sprinkler head behind the dryers in laundy room is installed correctly and is free of foreign materials. All meet	SHADY N	NOOK CARE CENT	ER	LAWR	ENCEBURG, IN 47025		
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maintained. The sprinkler head behind the dryers in laundry room is installed correctly and is free of foreign materials. All meet							
behind the dryers in laundry room is installed correctly and is free of foreign materials. All meet					· ·		
is installed correctly and is free of foreign materials. All meet					•		
foreign materials. All meet					-		
						= :	
					_	/as	
affected by this potential practice.					•		

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Event ID:

KEUK21

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identified by:

Other Residents that have the potential to be affected have been

Residents and staff could be

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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 <u>01</u>			COMPLETED	
		155525	B. WING 12/05/2024				2024
NAME OF T	DROLUDED OF CURRY WAS			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	:		36 VILL	AGE DRIVE		
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	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
					affected by this alleged deficit		
					practice. All sprinkler heads		
					reviewed and assessed to ensing accordance to meet	sure	
					compliance. Please see below	,	
					measures implemented to pre		
					reoccurrence.	VOIIL	
					The measures or systemic		
					changes that have been put in	ito	
					place to ensure that the deficie		
					practice does not recur include		
					In-service completed with		
					maintenance director,		
					housekeeping director and		
					administrator. Review initiated	to	
					ensure that sprinkler heads sh	ıall	
					maintain compliance and mee		
					regulations. This will be discus		
					as part of operational morning	and	
					afternoon meetings.		
					The corrective action taken to		
					monitor performance to assure	Э	
					compliance through quality		
					assurance:		
					A performance improvement to		
					has been initiated to ensure the		
					sprinkler heads meet compliar without foreign materials. A	iU <del>U</del>	
					Quality Assurance Audit Tool	will	
					be completed by the maintena		
					director/designee daily x3 wee		
					weekly X3 weeks, monthly for		
					months, then quarterly for 2	-	
					quarters. Any identified issues	will	
					be immediately addressed. Th		
					outcomes will be reviewed thro		
					the facility Quality Assurance	-	
					Program. Monitoring will contil	nue	
					as planned or will be increase		
					the Quality Assurance Commi	ttee	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	î ´			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155525	B. W	ING		12/05/	2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  36 VILLAGE DRIVE LAWRENCEBURG, IN 47025				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					if needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee if warra based on the outcome of tools The date the systemic change will be completed: 12/09/24	inted	
K 0355	NFPA 101						
SS=E Bldg. 01	Portable Fire Extir	nguishers					
	failed to ensure 4 of the Maintenance Of accordance with NF Fire Extinguishers, states portable fire extractions wheeled extinguisher of the following me intended for the extractions where the extractions in the office of the extractions of the following me intended for the extractions of the extractions of the extractions of the extraction of the e	were sitting on the floor and ased on interview at the time of D agreed the extinguishers in the floor and were	K 0	355	By submitting the enclosed material, we are not admittin the truth or accuracy of any specific findings or allegatio. We reserve the right to content 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 12/25/2024 for the Emergency Preparedness survey date 12/05/24 and for Life and Safety recertification and state licensure survey conducted on 12/05/24. We respectfully request a paper review and will provide any additional information requested.  K355  It is the practice of this facilit to ensure that portable fire	ns. est s the	12/25/2025
	_	viewed with the Maintenance			extinguishers are maintained		
	Director and Admin	nistrator during the exit			in accordance with NFPA 10°	1:	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) M	ULTIPLE CO	NSTRUCTION (X3) DATE		E SURVEY	
		IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155525	B. W	NG	·	12/05/	12/05/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					AGE DRIVE		
SHADY NOOK CARE CENTER					ENCEBURG, IN 47025		
SHADIT				LAWIN			
(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
	conference.				LSC chapter 9, ensuring that	t	
					they are installed properly.		
	3.1-19(b)						
					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 fire extinguisher	's	
					are maintained and installed	. 4	
					fire extinguishers in the		
					maintenance office were		
					disposed of properly since		
					expired.		
					Other Residents that have the	he	
					potential to be affected have	)	
					been identified by:		
					This deficit has the potentia		
					affect 2 staff. All extinguishe	rs	
					have been reviewed and	ļ	
					assessed to ensure in		
					accordance to meet		
					compliance. Please see belo	W	
					measures implemented to		
					prevent reoccurrence.		
					The measures or systemic	ļ	
					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	ed	
					to ensure that fire		
					extinguishers shall maintain		

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 12/05/2024
	ROVIDER OR SUPPLIE		36 VILI	ADDRESS, CITY, STATE, ZIP COD LAGE DRIVE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings.	
				The corrective action taken monitor performance to assi compliance through quality assurance:	
				A performance improvement tool has been initiated to ensure that securing fire extinguishers meet compliant with securing and maintaining A Quality Assurance Audit To will be completed by the maintenance director/designed daily x3 weeks, weekly X3 we monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The	nce ng. ol
				outcomes will be reviewed thre the facility Quality Assurance Program. Monitoring will continuous planned or will be increased the Quality Assurance Commif needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee if warrance based on the outcome of tools.	inue ed by ittee will anted
				The date the systemic chan will be completed: 12/25/24	ges

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Event ID:

KEUK21 Facility ID: 000304

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			JILDING	<u>01</u>	COMPLETED		
		155525	B. Wl	NG		12/05/20	
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			•	36 VILL	ADDRESS, CITY, STATE, ZIP COD LAGE DRIVE ENCEBURG, IN 47025		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0521 SS=F Bldg. 01	failed to ensure egre a portion of a return rooms for 47 of	on and interview, the facility ess corridors were not used as a air system serving adjoining resident rooms. LSC 9.2.1 oning, heating, ventilating ed equipment to be installed in PA 90A, the Standard for the Conditioning and Ventilating A, Section 4.3.12.1.1 states nursing and long term care e used as a portion of a chaust air system serving ess otherwise permitted by a 4.3.12.1.3.4. This deficient that all residents, as well as staff on the corduring a tour of the facility end at the system. Based on the observations, the cord confirmed the forty seven the using the egress corridor as a chaust air system. Based on the observations, the cord confirmed the forty seven the using the egress corridor as a chaust air system. Based on the observations, the cord confirmed the forty seven the using the egress corridor as a chaust air system.	K 0	521	By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We rest the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect 12/05/24 to the Recertification State Licensure Survey compliance on December 05, 2024. We respectfully request a paper reand will provide any additional information requested. K521 Please see attached Life & sa waiver request form.  The facility has been granted a waiver for K021 each year sinterior 1990, when the tag was first of Following the 1990 survey, the facility had installed a system whereby the activation of the falarm, including the automatic sprinkler system and the automatic smoke detection wo shut down the supply air fans. In 1990, the facility obtained a estimate from a contractor to install return air ducts in each resident's room. The cost at the time was approximately	fic serve so or se	12/05/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	JLTIPLE CO JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED		
		155525	B. WING 12/05/2024				
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD  36 VILLAGE DRIVE  LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					\$29,782.00. All fire protection devices are tested by Safe Care on an anr basis. Sprinkler system tested by Sa Care quarterly. Facility maintenance conducts fire dril quarterly on shifts (1) and (2) valarm is tripped.	fe Is	
K 0923 SS=E Bldg. 01	Storag	Cylinder and Container					
	failed to ensure 1 of gases such as oxyge falling. NFPA 99, I 2012 Edition, Section nonflammable gases (300 cubic feet) but (3000 cubic feet) but (3000 cubic feet) sh through 11.3.2.3. No cylinder or container 11.6.2.3. Section 11 cylinders shall be primal proper cylinder practice could affect Findings include:  Based on observation Maintenance Direct facility from 1:45 proxygen cylinder in the Street Hall was stand was not properly checylinder stand or care	ons and interview with the or (MD) during a tour of the .m. to 4:15 p.m. on 12/05/24, one the nurse's station on the "D" ding upright on the floor and ained or supported in a proper rt.	K 09	923	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegation. We reserve the right to content 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 12/25/2024 for the Emergency Preparedness survey date 12/05/24 and for Life and Safety recertification and state licensure survey conducted on 12/05/24. We respectfully request a paper review and will provide any additional information requested.	ns. est r the	12/25/2024
	The Maintenance D know better than to	irector stated that the staff do this.			<u>K923</u> It is the practice of this facilit to ensure that portable O2	t <b>y</b>	

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER   155525   B. WING	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
NAME OF PROVIDER OR SUPPLIER  SHADY NOOK CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG COMPLETION DATE  This finding was acknowledged by the MD at the time of facility tour and again at the exit conference with the MD and Administrator present.  3.1-19(b)  STREET ADDRESS, CITY, STATE, ZIP COD 36 VILLAGE DRIVE LAWRENCEBURG, IN 47025  ID PROVIDERS PLAN OF CORRECTION (X5) COMPLETION DEFICIENCY COMPLETION DATE  Cylinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  The corrective action taken for			IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>		4PLETED	
SHADY NOOK CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  This finding was acknowledged by the MD at the time of facility tour and again at the exit conference with the MD and Administrator present.  SHADY NOOK CARE CENTER  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE  CYlinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  3.1-19(b)  The corrective action taken for			B. WING 12/05/2024						
SHADY NOOK CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  This finding was acknowledged by the MD at the time of facility tour and again at the exit conference with the MD and Administrator present.  SHADY NOOK CARE CENTER  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERDED TO THE APPROPRIATE DEFICIENCY) DATE  Cylinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  3.1-19(b)  The corrective action taken for					STREET A	ADDRESS CITY STATE ZIP COD			
CX4   ID   SUMMARY STATEMENT OF DEFICIENCIE   ID   PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE      This finding was acknowledged by the MD at the time of facility tour and again at the exit conference with the MD and Administrator present.   3.1-19(b)      The corrective action taken for   CX5   COMPLETION (COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     COMPLETION DATE     CYLINDER APPROPRIATE DEFICIENCY     COMPLETION DATE     COM	NAME OF PROVIDER OR SUPPLIER								
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  This finding was acknowledged by the MD at the time of facility tour and again at the exit conference with the MD and Administrator present.  3.1-19(b)  PREFIX PREFIX CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE  COMPLETION DATE  COMPLETION DATE  TAG  TAG  TAG  TAG  TAG  TAG  TAG	SHADY NOOK CARE CENTER								
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG Cylinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  3.1-19(b)  TAG Cylinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  The corrective action taken for	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG Cylinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  3.1-19(b)  TAG DEFICIENCY)  Cylinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  The corrective action taken for	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
time of facility tour and again at the exit conference with the MD and Administrator present.  3.1-19(b)  accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.  The corrective action taken for	TAG				TAG	DEFICIENCY)		DATE	
conference with the MD and Administrator present.  3.1-19(b)  Chapter 11, ensuring that they are secured and stored properly.  The corrective action taken for		_							
present.  3.1-19(b)  are secured and stored properly.  The corrective action taken for		1	•			accordance with NFPA 99:			
3.1-19(b) properly.  The corrective action taken for		conference with the MD and Administrator				chapter 11, ensuring that the	<b>y</b>		
3.1-19(b)  The corrective action taken for		present.				are secured and stored			
The corrective action taken for						properly.			
		3.1-19(b)							
						The corrective action taken	for		
those residents found to be						those residents found to be			
affected by the deficient						affected by the deficient			
practice include:						practice include:			
It is the policy of this facility to							to		
ensure that 02 cylinders are						_			
maintained and stored in a O2									
caddy or in O2 cylinder rack						_			
and meet safety regulation.									
One 02 cylinder is stored in Dst						<u>-</u>			
nurses' station in an O2 caddy.							-		
All oxygen cylinders meet this							is		
standard.						standard.			
Other Residents that have the						Other Residents that have the	<b>1</b> е		
potential to be affected have						potential to be affected have			
been identified by:						been identified by:			
This deficit has the potential to						_			
affect staff and residents. All O2							_		
cylinders have been reviewed						cylinders have been reviewe	d		
and assessed to ensure in						and assessed to ensure in			
accordance to meet									
compliance. Please see below						compliance. Please see belo	w		
measures implemented to						measures implemented to			
prevent reoccurrence.						prevent reoccurrence.			
The measures or systemic						The measures or systemic			
changes that have been put						changes that have been put			
into place to ensure that the						into place to ensure that the			
deficient practice does not						deficient practice does not			
recur include:						recur include:			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/05/2024	
	ROVIDER OR SUPPLIEI		36 VIL	ADDRESS, CITY, STATE, ZIP COD LAGE DRIVE ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OF	K LSC IDENTIFYING INFORMATION	TAG	In-service completed with maintenance director and administrator. All staff in serviced on correct handling and maintaining. The review was initiated to ensure that extinguishers shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings.  The corrective action taken monitor performance to assicompliance through quality assurance:  A performance improvement tool has been initiated to ensure that oxygen cylinder meet compliance and are stored, secured and maintained. A Quality Assurated the maintenance director/desidaily x3 weeks, weekly X3 we monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately 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 warrance. Additional action be taken by the Quality Assurance Committee if warrance. Committee if warrance Committee if warrance.	to ure  to genee by genee beks,  rough inue d by ittee will

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPI A. BUILDIN B. WING		nstruction  01	(X3) DATE COMPL 12/05/	ETED
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			36	VILL	ADDRESS, CITY, STATE, ZIP COD AGE DRIVE NCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					based on the outcome of tools		
					The date the systemic chang will be completed: 12/25/24	jes	

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