STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155525	A. BUILDING -- B. WING	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SHADY NOOK CARE CENTER	36 VILLAGE DRIVE LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/05/24 Facility Number: 000304 Provider Number: 155525 AIM Number: 100266810 At this Life Safety Code survey, Shady Nook Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 94 certified beds. At the time of the survey, the census was 85. Quality Review completed on 12/09/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/05/24 Facility Number: 000304 Provider Number: 155525 AIM Number: 100266810 At this Life Safety Code survey, Shady Nook Care Center was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsey Boltz		12/26/2024

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

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 85 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 12/09/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General 1) Based on observation and interview, the facility failed to ensure 1 of 1 corridor means of egress on the Memory Care Hall was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice affects 26 residents and staff in the facility. Findings include: Based on observations and interview with the Maintenance Director (MD) during a tour of the facility from 1:45 p.m. to 4:15 p.m. on 12/05/24, in the Memory Care Hall a large blue reclining chair was in use, occupied by a resident, and	K 0211	Section 1: By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/25/2024 for the Emergency Preparedness survey date	12/25/2024

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	positioned near the exit door, obstructing the exit. Based on an interview at the time of observations, the MD stated the chair is usually not in the corridor obstructing the exit door. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of over 4 exit discharges had a level walking surface, was free of obstructions or impediments for full instant use in the case of fire or other emergency. This deficient practice could affect 15 residents and staff. Findings include: Based on observations and interview with the Maintenance Director (MD) during a tour of the facility from 1:45 p.m. to 4:15 p.m. on 12/05/24, the exit discharge near the Hair Care had two large mats on the landing. The Administrator stated staff stand on the mats in the salon and someone had moved them outside to clean and forgot to return them to where they were used. The large mats positioned on the landing outside the exit door created an obstruction leading to the common way. 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)		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. K211 It is the practice of this facility to ensure that all means of egress are maintained in accordance with NFPA 101: LSC chapter 7, ensuring that they remain clear of obstacles. The corrective action taken for those residents found to be affected by the deficient practice include: It is the policy of this facility to ensure that all means of egress are maintained and free of obstacles. The emergency exit on the west end of the memory care hall is free of obstacles and is maintained to allow movement to emergency exit. 7 of 7 corridors meet this standard. Other Residents that have the potential to be affected have been identified by: This deficit has the potential to affect staff, residents, and visitors. All emergency corridors were reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. The measures or systemic changes that have been put into place to ensure that the deficient	

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			practice does not recur include: In-service completed with maintenance director and administrator. All staff in-service completed re: maintaining emergency corridors; free of obstructions. Review initiated to ensure that emergency corridors shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. The corrective action taken to monitor performance to assure compliance through quality assurance: A performance improvement tool has been initiated that observes corridors and maintains compliance related to life and safety. A Quality Assurance Audit Tool will be completed by the maintenance director or designee daily x3 weeks, weekly X3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring and education will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. The date the systemic changes	

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			will be completed: 12/25/24 Section 2: By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/25/2024 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. K211 It is the practice of this facility to ensure that all means of egress are maintained in accordance with 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 practice include: It is the policy of this facility to ensure that all means of egress are maintained and are of level surface. The emergency exit near the hair salon is free of obstacles and is maintained level to allow movement through emergency	

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			exit. 7 of 7 exits meet this standard. Other Residents that have the potential to be affected have been identified by: This deficit has the potential to affect staff, residents, and visitors. All emergency exits were reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: In-service completed with maintenance director and administrator. In-service completed with all staff to ensure compliance in maintaining surface level at means of egress. Review initiated to ensure that emergency exits shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. The corrective action taken to monitor performance to assure compliance through quality assurance: A performance improvement tool has been initiated that audits all means of egress and maintains current compliance for surface level at each means of egress. A Quality Assurance Audit Tool will be completed by the maintenance director or designee daily x3	

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			weeks, weekly X3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. The date the systemic changes will be completed: 12/25/24	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to maintain the ceiling construction behind the dryers. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 3 laundry staff. Findings include: Based on observations and interview with the Maintenance Director (MD) during a tour of the facility from 1:45 p.m. to 4:15 p.m. on 12/05/24, behind the dryer there was a hole where a sprinkler head may have been located. The MD agreed there was a hole in the ceiling where it	K 0353	Section One: By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 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	12/09/2024

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	appeared a sprinkler head was once located. The MD was unsure if a sprinkler head had been removed and stated he would investigate. This finding was reviewed with the Maintenance Director and Administrator during the exit conference 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 3 laundry staff. Findings include: Based on observations and interview with the Maintenance Director (MD) during a tour of the facility from 1:45 p.m. to 4:15 p.m. on 12/05/24, 1 of 1 sprinkler heads behind the dryers in the laundry room were coved in dust or showed signs of loading. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		12/05/24. We respectfully request a paper review and will provide any additional information requested. K353 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 installed with no gaps allowing movement of heat. 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 laundry room is installed correctly and ceiling around head is maintained intact. All sprinklers heads meet this standard, no residents were found to be affected by the potential deficit practice. Other Residents that have the potential to be affected have been identified by: This deficit has the potential to affect staff and residents. All sprinkler heads reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: In-service completed with	

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			maintenance director, housekeeping director and administrator re: Sprinkler head maintenance. Review initiated to ensure that sprinkler heads shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. The corrective action taken to monitor performance to assure compliance through quality assurance: A performance improvement tool has been initiated that audits sprinkler heads and maintains current standards for sprinklers. A Quality Assurance Audit Tool will be completed by the maintenance director/designee daily x3 weeks, weekly X3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. The date the systemic changes will be completed: 12/09/24 Section 2: By submitting the enclosed material, we are not admitting the truth or accuracy of any specific	

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			findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 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. K353 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 laundry room is installed correctly and is free of foreign materials. All meet compliance and no resident was affected by this potential practice. Other Residents that have the potential to be affected have been identified by: Residents and staff could be	

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			affected by this alleged deficit practice. All sprinkler heads reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: In-service completed with maintenance director, housekeeping director and administrator. Review initiated to ensure that sprinkler heads shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. The corrective action taken to monitor performance to assure compliance through quality assurance: A performance improvement tool has been initiated to ensure that sprinkler heads meet compliance without foreign materials. A Quality Assurance Audit Tool will be completed by the maintenance director/designee daily x3 weeks, weekly X3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee	

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			if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools The date the systemic changes will be completed: 12/09/24	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguishers in the Maintenance Office were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect 2 staff in the office. Findings include: Based on observations and interview with the Maintenance Director (MD) during a tour of the facility from 1:45 p.m. to 4:15 p.m. on 12/05/24, four ABC portable fire extinguishers in the Maintenance Office were sitting on the floor and were unsecured. Based on interview at the time of observation, the MD agreed the extinguishers were sitting loose on the floor and were unsecured. This finding was reviewed with the Maintenance Director and Administrator during the exit	K 0355	**By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/25/2024 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.** ***K355*** **It is the practice of this facility to ensure that portable fire extinguishers are maintained in accordance with NFPA 101:**	12/25/2025

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	conference. 3.1-19(b)		**LSC chapter 9, ensuring that they are installed properly.** **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 extinguishers are maintained and installed. 4 fire extinguishers in the maintenance office were disposed of properly since expired.** **Other Residents that have the potential to be affected have been identified by:** **This deficit has the potential to affect 2 staff. All extinguishers have been reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence.** **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** **In-service completed with maintenance director and administrator. Review initiated to ensure that fire extinguishers shall maintain**	

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			compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** **A performance improvement tool has been initiated to ensure that securing fire extinguishers meet compliance with securing and maintaining.** A Quality Assurance Audit Tool will be completed by the maintenance director/designee daily x3 weeks, weekly X3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. **The date the systemic changes will be completed: 12/25/24**	

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K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 47 of 47 resident rooms. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations and interview with the Maintenance Director during a tour of the facility from 1:45 p.m. to 4:15 p.m. on 12/05/24, all forty seven resident rooms were using the egress corridor as a return air system. Based on interview at the time of the observations, the Maintenance Director confirmed the forty seven resident rooms were using the egress corridor as a return air system. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)	K 0521	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/05/24 to the Recertification and State Licensure Survey completed on December 05, 2024. We respectfully request a paper review and will provide any additional information requested. K521 Please see attached Life & safety waiver request form. The facility has been granted a waiver for K021 each year since 1990, when the tag was first cited. Following the 1990 survey, the facility had installed a system whereby the activation of the fire alarm, including the automatic sprinkler system and the automatic smoke detection would shut down the supply air fans. In 1990, the facility obtained an estimate from a contractor to install return air ducts in each resident's room. The cost at that time was approximately	12/05/2024

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	155525	A. BUILDING 01 B. WING	12/05/2024

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			$29,782.00. All fire protection devices are tested by Safe Care on an annual basis. Sprinkler system tested by Safe Care quarterly. Facility maintenance conducts fire drills quarterly on shifts (1) and (2) when alarm is tripped.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 5 staff. Findings include: Based on observations and interview with the Maintenance Director (MD) during a tour of the facility from 1:45 p.m. to 4:15 p.m. on 12/05/24, one oxygen cylinder in the nurse's station on the "D" Street Hall was standing upright on the floor and was not properly chained or supported in a proper cylinder stand or cart. The Maintenance Director stated that the staff know better than to do this.	K 0923	**By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/25/2024 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.** ***K923*** **It is the practice of this facility to ensure that portable O2**	12/25/2024

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	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)		**cylinders are maintained in accordance with NFPA 99: chapter 11, ensuring that they are secured and stored properly.** **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 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 nurses' station in an O2 caddy. All oxygen cylinders meet this standard.** **Other Residents that have the potential to be affected have been identified by:** **This deficit has the potential to affect staff and residents. All O2 cylinders have been reviewed and assessed to ensure in accordance to meet compliance. Please see below measures implemented to prevent reoccurrence.** **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:**	

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			In-service completed with maintenance director and administrator. All staff in serviced on correct handling and maintaining. The review was initiated to ensure that fire extinguishers shall maintain compliance and meet regulations. This will be discussed as part of operational morning and afternoon meetings. **The corrective action taken to monitor performance to assure compliance through quality assurance:** **A performance improvement tool has been initiated to ensure that oxygen cylinders meet compliance and are stored, secured and maintained.** A Quality Assurance Audit Tool will be completed by the maintenance director/designee daily x3 weeks, weekly X3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted	

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			based on the outcome of tools. **The date the systemic changes will be completed: 12/25/24**	