

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

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2024
NAME OF PROVIDER OR SUPPLIER WILLOWS OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00433897, IN00434609, IN00435564, and IN00435642.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to Investigation of Complaints IN00429302, IN00432416, IN00432418, IN00432991, and IN00433278 completed on 5/2/2024.</p> <p>Complaint IN00433897 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00434609 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00435564 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00435642 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00429302 - Corrected</p> <p>Complaint IN00432416 - Corrected</p> <p>Complaint IN00432418 - Corrected</p> <p>Complaint IN00432991 - Corrected</p> <p>Complaint IN00433278 - Corrected</p> <p>Survey dates: June 5, 2024</p> <p>Facility number: 000009 Provider number: 155022 AIM number: 100274760</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2024
NAME OF PROVIDER OR SUPPLIER WILLOWS OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 000	<p>Continued From page 1</p> <p>Census Bed Type: SNF/NF: 59 Total: 59</p> <p>Census Payor Type: Medicare: 4 Medicaid: 40 Other: 15 Total: 59</p> <p>Willows of Shelbyville was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the Investigation of Complaints IN00433897, IN00434609, IN00435564, and IN00435642.</p> <p>Quality review completed on June 6, 2024</p>	F 000			