STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 00 B. WING	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

(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
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 11, 2023. This visit included a PSR to the State Residential Survey completed on January 11, 2023. This visit included a PSR to the Investigation of Complaint IN00385727 completed on January 11, 2023. Complaint IN00385727 - Not Corrected. Survey dates: February 7 and 8, 2023 Facility number: 004268 Provider number: 155735 AIM number: 200504460 Census Bed Type: SNF/NF: 36 SNF: 15 Residential: 22 Total: 73 Census Payor Type: Medicare: 13 Medicaid: 29 Other: 9 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 14, 2023	F 0000	The submission of this plan of correction does not indicate an admission by Ashford place health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Ashford place health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zachary Simpson	Executive Director	02/22/2023

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	medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document that self administration of medications and treatments were clinically appropriate for 2 of 3 residents randomly observed for medications at bedside. (Resident 5 and 22) Findings include: A random observation of Resident 5 and 22's room was made on 2/8/2023 at 11:31 a.m. with LPN (Licensed Practical Nurse) 2. Resident 5 had a jar of hydrocortisone 2.5% (anti-itch medication) by her bedside on the nightstand and Resident 22 had a tube of Biofreeze (pain relief creme) and a bottle of 30 gram nystatin (anti-fungal medication) on the windowsill next to her bed. The medications had the facility's pharmacy label affixed to them. The hydrocortisone 2.5% jar's pharmacy label indicated, it had been dispensed by the facility's pharmacy on 10/25/22. The Biofreeze tube's label indicated, it had been originally dispensed by the pharmacy on 4/21/22 and the nystatin bottle's label indicated, a dispensed date of 8/2/22. The facility was unable to locate completed self-medication administration assessments for neither Resident 5 nor 22. The clinical record for Resident 5 was reviewed on 2/8/23 at 12:02 p.m. Resident 5's diagnoses included, but not limited to, chronic kidney disease and diabetes type I. Resident 5's orders did not contain an active order for the	F 0554	1. Residents 5 and 22 were affected by alleged deficient practice. A self-administration assessment was completed on resident 22. Resident 22 able to successfully self-administer preferred medications per assessment findings. Meds were immediately removed from resident 5 bedside and assessment conducted without findings. ~~2.~~ All like residents have the potential to be affected by alleged deficient practice. Health Care Center audit of like residents was completed to ensure proper self-administration assessment completed for residents who preferred to self-administer. Licensed staff were in-serviced on self-administration policy. ~~3.~~ As a measure of ongoing compliance, the DHS or designee will round each room twice a day 5 times per week for medications at bedside without a self-administration assessment for 4 weeks, then each room once daily for 4 weeks, then each room weekly x4 months.- 4. As a quality measure, the Executive Director (ED) or	02/10/2023

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	hydrocortisone 2.5% cream. The hydrocortisone 2.5 % cream had been discontinued on 11/24/22. The clinical record for Resident 22 was reviewed on 2/8/23 at 12:07 p.m. Resident 22's diagnoses included, but not limited to, Alzheimer's disease, major depressive disorder, and psychotic disorder with delusions. Resident 22's quarterly MDS (minimum data set) dated 12/5/22 indicated, she was moderately cognitively impaired. An interview with DON (Director of Nursing) was conducted on 2/8/23 at 4:36 p.m. DON indicated, the facility's plan of correction dated 2/1/23 had focused on asking residents, who were recently admitted to the facility, if they would like to self-administer their medications she had not focused on medications being left at the bedside by staff. A Guidelines for Self-Administration of Medication policy was received on 2/8/23 at 4:26 p.m. The policy indicated, "...Purpose. To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care. Procedures. 1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self medication. a. The order should include the type of medication(s) the resident is able to self-medicate. i.e: [that is] all oral meds, oral meds with the exception of..., nebulizer treatment only, all medications including injection, oral, inhalers, drops, etc. 2. The resident and/or family/responsible party will be informed of the		designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	results of the assessment and whether the resident has been determined to safely self-administer medications...6. A Self-Medication plan of care will be initiated and updated as indicated..." 3.1-11			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate			

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	corrective action must be taken. Based on interview and record review, the facility failed to report timely to the Indiana Department of Health (IDOH) an injury (a fracture) of unknown origin for 1 of 3 residents reviewed for abuse. (Resident 44) Findings include: An incident report was received from ED (Executive Director) on 2/7/23 at 2:35 p.m. The incident report dated 2/2/23 indicated, Resident 44 who had diagnoses including, but not limited to, dementia, osteoarthritis, and protein malnutrition, was found to have a swollen left hand on 1/30/23. The brief description of the incident indicated, "2/2/2023 Staff observed patients[sic, patient's] hand was swollen during breakfast. [sic] Denied pain to area. [sic] Unable to state the cause of the swelling. [sic] Able to move fingers without complaints of pain." The type of injury noted "2/2/2023 acute avulsion fracture of 1st metacarpal from results received on 2/2/23. An IDT (Interdisciplinary Team) note for Resident 44 dated 1/31/23 indicated, Resident 44 was observed by the writer, on that day, to have edema present to his left hand/wrist. Both of Resident 44's hands/fingers were noted to have contractures, but there weren't any open areas or bruising present. Resident 44's Nurse Practitioner (NP) was made aware of the swelling to his left hand and ordered an x-ray. An imaging report for Resident 44 dated 2/1/23 indicated, "Avulsion fracture distal 1st metacarpal presumably acute".	F 0609	1. Resident 44 was not affected by the alleged deficient practice. Resident was assessed by a licensed nurse and the follow up revealed there was not a fracture. Resident continues to have no complaints. 2. All like residents have the potential to be affected. No other residents were affected. Executive Director and Director of Health Services were educated on timely reporting guidelines. Staff educated on notification of timely reporting to ED/DHS. 3. As a measure of ongoing compliance, the Executive Director, Director of Health Services, or designee will audit potential injuries that need reported timely in clinical care meeting to ensure compliance with the reporting policy and state guidelines. Audit will be completed 5 times a week x 4 weeks, 3 times a week x 8 weeks, and then weekly x 3 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan	02/10/2023

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	A nursing note dated 2/1/23 at 1:49 p.m. indicated, the swelling to Resident 44's left hand remains, the x-ray was completed that morning and the results were reported to the NP. An interview with ED (Executive Director) was conducted on 2/8/23 at 12:18 p.m. ED indicated, because the imaging report had used the word "presumably" confusion arouse and the facility asked for a "re-read" on the imaging report. ED indicated, he believed the report had said "presumably" a fracture and not a "presumably acute" fracture. The facility waited to report the fracture until the re-read imaging report was received however, the re-read imaging report was the same as the original report. Resident 44's clinical record did not contain any information regarding the request to have the imaging re-read, or a repeat X-ray was performed. An abuse policy was provided by DON (Director of Nursing) on 2/8/23 at 2:35 p.m. It indicated, "...Purpose. Trilogy Health Services (THS), LLC, has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure. 4...g. Reporting/response i. Any staff member, resident, visitor or resident representative may report known or suspected abuse, exploitation, neglect, or misappropriation to local or state agencies. ii. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if		will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where the state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures...iv. A written report of the investigation outcome, including resident response and/or condition, final conclusion, and actions taken to prevent reoccurrence will be submitted to the applicable State Agencies within five days..." 3.1-28(e)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program by not ensuring contact precaution signage was in place for two residents who had VRE (Vancomycin resistant entrococcus) in their urine for 2 of 3 residents reviewed for infection prevention and control. (Residents 19 and 52) Findings include: 1. The clinical record for Resident 19 was reviewed on 2/7/23 at 3:14 p.m. Resident 19's diagnoses included, but not limited to, urinary tract infection, congestive heart failure, and chronic obstructive pulmonary disease. Resident 19's discharge instructions from a local hospital dated 2/4/23 indicated, Resident 19's urine had been tested for a UTI (urinary tract infection). Resident 19's urine culture final report dated 2/2/23 indicated, growth of Enterococcus faecium >100,000 cfu/ml (colony forming units per milliliter) and was resistant to Vancomycin (an antibiotic). A physician's order dated 2/6/23 indicated, to place Resident 19 on contact precautions related to VRE in her urine. 2. The clinical record for Resident 52 was reviewed on 2/7/23 at 3:20 p.m. Resident 52's	F 0880	1. Resident 19 was not affected by alleged deficient practice. New signage placed to ensure specific isolation donning and doffing and PPE requirements. 2. All residents have the potential to be affected. Licensed staff has been educated on the following CDC and facility policy. The Executive Director (ED), Director of Health Services (DHS), Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. 3. As a measure of ongoing compliance, the following audits and/or observations for 3 residents will be conducted by the ED,	02/10/2023

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	diagnoses included, but not limited to, cerebral infarction (stroke) affecting left side and urinary tract infection. Resident 52's hospital record from a local hospital dated 1/2/23 indicated, Resident 52's urine had been tested for a UTI. Resident 52's urine culture indicated, Enterococcus faecium VRE >100,000 cfu/ml. A physician's order indicated, to place Resident 52 on contact precautions related to VRE in her urine. An observation of Resident 19 and 52's rooms on 2/8/23 at 10:45 a.m. and 10:57 a.m. respectively was made with IP (Infection Preventionist). On both residents' door frames was a sign posted which was green in color and stated "Green Zone". On both of the residents' doors were two signs. One had a red stop sign on it which indicated, to stop and see the nurse before entering and the other was a white sign which indicated what PPE (personal protective equipment) to wear when caring for a resident suspected of or with a confirmed case of COVID-19. Neither Resident 19 nor 52 were suspected or had a confirmed case of COVID-19. An interview with IP was conducted at the same time as the observations. IP indicated, the "Green zone" sign indicated, the resident in the room did not have COVID-19. She admitted the white sign with the PPE information for COVID-19 did not indicate the correct signage for VRE in the urine. She indicated, the correct isolation precaution signage should be for contact precautions. During the interview with IP, Resident 19's daughter and HSK (housekeeper) 4 had approached IP and indicated, the signage that was		campus IP, or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance of proper signage placement on isolation room doors. Monitoring / auditing of this plan of correction will occur every day: Residents requiring contact precautions will have specific signage on the door. Additionally monitoring/Auditing staff PPE donning and doffing with return demonstration. All findings from the RCA, if different from current audit, will result in additional audits. The ED, campus IP, or designee will round the campus daily to ensure appropriate infection control practices are maintained and for any needs as determined from RCA findings for a minimum of 6 weeks and will continue thereafter until compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	on the doors and doorframes was confusing. Resident 19's daughter indicated, she wasn't sure what PPE she needed to where while visiting her mother. HSK 4 indicated, she had been unsure of what PPE she needed to wear when cleaning the resident's room versus her bathroom. A Guidelines for Contact Precautions policy was received on 2/8/23 at 4:26 p.m. The policy indicated, "Procedures 1. Contact precautions is a method designed to reduce the risk of transmission of microorganisms by direct or indirect methods...2. Contact Precautions are indicated to prevent and control HAI (health-care associated infections) transmission of infection with any of the following: a. Vancomycin resistant enterococcus species. (VRE)... 3. Standard Precautions such as wearing gloves, good hand washing before, after procedures and between residents should always be followed... 5. Personal Protective Equipment: a. Wear gloves before contact with the resident or environmental objects. Change gloves and wash hands after having direct contact with the resident, possible infective material, or potentially contaminated with blood or body secretions in a biohazard container. b. Wear a clean non-sterile, fluid resistant gown when entering the room if it is anticipated clothing will have substantial contact with the resident or environmental surface or when there is likelihood that organisms from blood, urine, stool, or wound drainage may be on surfaces or items in the resident's rooms. c. Substantial contact is defined when the worker can anticipate that his/her clothing will be directly in contact with the resident, resident's linens, or bed... 6. Precaution Sign:			

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	a. Post a sign at the resident's door to advise the visitors to report to nurses's station before entering the room." The Centers for Diseases and Control website last accessed on 2/9/23 at https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html indicated, "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) Implementation: When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility ' s expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves)..." This Federal Tag relates to complaint IN00385727. 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on January 11, 2023. This visit included a PSR to the Recertification, State Licensure and complaint IN00385727 Survey completed on January 11, 2023 Survey dates: February 7 and 8, 2023 Facility number: 004268 Residential Census: 22	R 0000	The submission of this plan of correction does not indicate an admission by Ashford place health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Ashford place health campus. The facility recognizes its obligation to provide	

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	155735	A. BUILDING 00 B. WING	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

(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
	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 14, 2023		legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation, interview, and record review, the facility failed to ensure advocacy	R 0033	- **1.** No residents were affected	02/10/2023

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	addresses and telephone numbers were posted in an area accessible to residents for 22 of 22 residents in the facility. Findings include: A tour of the Assisted Living (AL) facility was conducted on 2/8/23 at 9:55 a.m. There was no posting of the addresses and telephone numbers to the IDOH (Indiana Department of Health,) the office of the secretary of family and social services, the ombudsman, the area agency on aging, a local mental health center, and adult protective services observed during the tour. An interview with ED (Executive Director) was conducted on 2/8/23 at 10:01 a.m. When asked where the advocacy information was posted, ED walked over to a credenza near the entrance to the AL, opened the top drawer and retrieved a stapled packet of paper and indicated the advocacy addresses, names, and phone numbers were listed in the packet. The packet of advocacy addresses and phone numbers was not available to the residents who reside in the Assisted Living on the dementia unit.		by the alleged deficient practice. **2.** All residents have the potential to be affected. Signage placed and hanging on wall on both Legacy Lane and Assisted Living. **3.** An audit will be conducted by ED or designee 5xs weekly for 1 month to ensure that the posting is in the correct place. Then 3xs weekly for 1 month and then 1x weekly once monthly for 4 months. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	