STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155478	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERS OF JASPER THE	2909 HOWARD DR JASPER, IN 47546

(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 the Investigation of Complaints IN00436159, IN00436199, and IN00431929. Complaint IN00436159 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00436199 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00431929 - No deficiencies related to the allegations are cited. Survey dates: June 19 & 20, 2024 Facility number: 000314 Provider number: 155478 AIM number: 100274210 Census bed type: SNF/NF: 66 Total: 66 Census payor type: Medicaid: 53 Other: 13 Total: 66 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 24, 2024.	F 0000	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 July 12th, 2024 to the complaint survey completed on June 20th, 2024. We respectfully request that a desk review be considered. The facility will provide additional information as needed to identify compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beau Kellams	Executive Director	07/07/2024

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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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure resident safety during transportation for 1 of 3 residents reviewed for accidents. A resident was improperly loaded onto a transportation vehicle lift causing the resident to fall backwards from a wheelchair onto the lift platform. (Activity Assistant 3, Resident B) Finding includes: During a review of facility reported incidents on 6/19/24 at 10:35 A.M., an incident that occurred on 6/3/24 at 2:45 P.M., indicated that Resident B was being transferred out of the facility transportation van and fell off the lift. Resident B was sent to the emergency room and received eight sutures to the right shin. During an observation and interview on 6/19/24 at 11:00 A.M., Resident B was sitting in her wheelchair in the dining room. Resident B indicated that she had fallen off of the facility transportation vehicle when the vehicle lift was not out properly. Resident B indicated she needed 8 stitches to her right leg and thinks she landed on a metal part of the lift which cut her leg. Resident B indicated the driver of the transportation vehicle had assisted her with the lift before and had always been able to do it by herself, calling the incident a "freak accident." During record review on 6/19/24 at 11:15 A.M., Resident B's diagnoses included, but were not	F 0689	**F689** It is the policy of Timbers of Jasper to ensure that the residents' environment remains free of accident hazards and that each resident receives adequate supervision and assistance to prevent accidents during transportation. **1. What corrective action will be accomplished for those residents found to be affected by the deficient practice?**Resident B was assessed and treated for injury. Resident B was assessed for any psychosocial ill effects following fall from the facility van. Resident B is being transported and assisted appropriately to prevent fall from van.Facility transportation driver present at time of fall was re-educated on safety measures and use of mechanical lift on the van.**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**All residents that use facility transport have the potential to be affected by this alleged deficient practice.Facility transportation drivers will be	07/12/2024

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	limited to, morbid obesity, muscle weakness, and unsteadiness on feet. Resident B's most recent annual MDS (Minimum Data Set) assessment, dated 5/23/24, indicated that the resident had no cognitive impairment, used a wheelchair for mobilization, and required partial to moderate assistance in the wheelchair. Resident B's nurse's progress notes included, but were not limited to the following: - On 6/3/24 at 7:20 P.M., Resident B returned to the facility post fall while at appointment. Resident was sent to emergency room from appointment due to the fall. Resident complained of pain to right lower extremity which was noted to have a laceration. Eight sutures were applied to the laceration. - On 6/4/24 at 5:02 P.M., IDT (Inter-disciplinary team) review, Resident B was on the facility bus being transferred onto the lift to be taken off the bus. Resident had fallen off the lift and sustained a laceration to the right lower extremity. Interventions put into place to address the root cause of fall included; ensure resident is secure on lift and ensure resident wheelchair brakes are locked and staff education on use of lift and securement of items. Bus was inspected with no mechanical issues found. During a review of the facility's investigation into the incident on 6/19/24 at 11:30 A.M., a signed written statement by Activity Assistant 3, dated 6/5/24, included, on 6/3/24, Activity Assistant 3 and Resident B arrived at at appointment at 2:10 P.M. on facility bus. Activity Assistant 3 parked bus, engaged, emergency break, proceeded to the back door, and lowered the mechanical lift. Activity Assistant 3 rode the lift up and unbuckled Resident B and took the restraints off,		re-educated on safety measures including documenting pre-trip and post-trip inspections. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**Facility transportation drivers will be re-educated on safety measures including documenting pre-trip and post-trip inspections. Daily Safety Observations will be completed by the Executive Director/designee.4. **How the corrective actions will be monitored to ensure the deficient practice will not recur?**The DNS/designee will complete transportation QAPI tool weekly x4 weeks, monthly x6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed.**Date of compliance: 7/12/24**	

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	then moved from the back of the bus to the front of the bus from inside the bus, removed the restraints and started backing resident out of bus onto the lift. Activity Assistant 3 noticed the mechanical lift was no longer all the way up. Activity Assistant 3 tried to pull Resident B back inside the bus but was not strong enough to pull her back in or hold her in place. Resident B, while in wheelchair, went off backwards. Activity Assistant 3 got off the bus and spoke to Resident B who was alert and oriented, then ran inside for help. Nurses came out and assessed Resident B and Emergency Medical Services were called. Resident B was loaded into ambulance and taken to hospital for evaluation. On 6/19/24 at 11:35 A.M., the DON (Director of Nursing) supplied a facility policy titled, Transportation, and dated 11/2015. The policy included, "...Requirements for resident transportation: 1. The driver must complete and document pre-trip inspections of the bus/van prior to resident transport..." During an interview and observation on 6/19/24 at 1:40 P.M., Activity Assistant 3 indicated that they completed a pre-trip inspection but did not document the inspection and do not use a check off sheet or inspection form to complete. Activity Assistant 3 then demonstrated what had happened on 6/3/24 while attempting to unload Resident B from the facility van/bus. Activity Assistant 3 indicated the lift was raised to allow her to get up in the back of the bus, however, when Resident B was being pushed backward onto the lift the lift had lowered due to an unknown reason to approximately six inches above the ground. This caused the metal plate that spanned the gap between the back of the van to the lift to rotate vertically, leaving a gap			

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	between the plate and the van. Activity Assistant 3 indicated Resident B's wheelchair went back into the gap and then flipped backwards allowing Resident B to fall an additional one foot onto the metal lift platform where she received a laceration to her right shin. Activity Assistant 3 indicated not knowing how the lift lowered after she had rode the lift up to the back of the van and indicated that the control may have been inadvertently pressed while getting around Resident B to detach the safety straps. During an interview on 6/19/24 at 1:55 P.M., the Maintenance Director indicated that the van and lift were inspected following the incident on 6/3/24 and that no mechanical issues were found and indicated that Resident B's fall was due to Resident B being improperly loaded onto the lift. On 6/20/24 at 11:21 A.M., Regional Nurse 5 supplied a facility policy titled Fall Management Policy, dated 3/2024. The policy included, "It is the policy of [Facility] to ensure residents residing within the community have adequate assistance to prevent injury related falls." This citation relates to Complaints IN00436159 and IN00436199. 3.1-45(a)(1) 3.1-45(a)(2)			