STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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 Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00403652 and a State Residential Licensure Survey. Complaint IN00403652 - No deficiencies related to the allegations are cited. Survey dates: April 24, 25, 26, 27, and 28, 2023 Facility number: 012854 Provider number: 155797 AIM number: 201104690 Census Bed Type SNF/NF: 32 SNF: 24 Residential: 19 Total: 75 Census Payor Type: Medicare: 19 Medicaid: 26 Other: 11 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 8, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during Annual survey conducted on April 28, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 19, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kellee Couch	Executive Director	05/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician of a change in a resident's condition for 1 of 18 resident's review. (Resident 15) Findings include: The record for Resident 15 was reviewed on 04/27/23 at 10:15 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/23/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertensive heart and chronic kidney disease with heart failure, hypertension, renal insufficiency, diabetes, non-Alzheimer's dementia, malnutrition, and depression. A Progress Note, dated 11/26/22 at 5:51 P.M., indicated the resident had a severe choking episode in the dining room. The CNA (Certified Nurse Aide) was able to clear the airway and assess that the resident was pocketing food. The vital signs and lung sounds were within normal limits. The resident's diet was downgraded to mechanical soft by the nurse pending a speech therapy evaluation. The record lacked documentation that the physician was notified of the choking incident on 11/26/22 until a speech therapy plan of treatment was signed on 12/02/22. During an interview on 04/27/23 at 1:31 P.M., the DON (Director of Nursing) indicated the record	F 0580	1. Resident 15 respiratory status has been assessed with no findings. Physician made aware. 2. All residents have the potential to be affected by alleged deficient practice. Health center residents medical records reviewed to ensure timely physician documentation is documented. 3. As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the policy of provider notification. DHS or designee will be responsible for auditing residents medical record during clinical care meeting to ensure physician notification was made. An audit of 5 residents will be conducted 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. ="" span="">warranted. ="" b="">4. As quality measure , the DHS or designees will review any findings and corrective action at least quarterly and ongoing until	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	lacked documentation the physician was notified and the physician should have been notified of any choking episodes. During an interview on 04/27/23 at 1:52 P.M., QMA (Qualified Medication Aide) 6 indicated if a resident had a choking episode she would assist the resident, then call the nurse that was in facility to assess the resident. The nurse would make a request for a speech therapy evaluation. If the incident happened on a weekend, she would call the weekend nurse supervisor and they could put in an immediate override of the resident's diet until the speech evaluation could be completed. The nurse was supposed to call and notify the physician and family of any changes in a resident's condition. The current facility policy, titled "Notification of Change in Condition" with an effective date of 05/10/2016 was provided by Clinical Support 4 on 04/27/23 at 2:46 P.M. The policy indicated, "...To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the physician and if known notify the resident's legal representative when: An accident involving the resident which results in an injury and has the potential for requiring physician intervention...A significant change in the resident's physical, mental or psychosocial status...A need to alter treatment significantly..." 3.1-5(a)(2)		campus achieves 100% compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	hygiene; Based on interview and record review, the facility failed to provide activities of daily living related to routine bathing for 1 of 24 residents reviewed. (Resident 26) Findings include: During an interview on 04/24/23 at 10:12 A.M., Resident 26 indicated she had been having a problem with getting showers. She usually only received one shower a week. The staff usually gave her showers in the morning. The record was reviewed on 04/25/23 at 10:58 A.M. An Admission MDS (Minimum Data Set) assessment, dated 02/26/23, indicated the resident was severely cognitively impaired. The resident required extensive assistance of one staff member for personal hygiene and bathing. The diagnoses included, but were not limited to, heart failure, arthritis, osteoporosis, stroke, and dementia. During an interview on 04/27/23 at 1:33 P.M., CNA (Certified Nurse Aide) 14 indicated residents were showered twice a week at a minimum. Bathing would be documented in the EHR (Electronic Health Record). They completed shower sheets (paper) sometimes as well. On 04/27/23 at 1:42 P.M., paper shower sheets from February through 04/27/23, were sorted with Clinical Support 2 and another staff member. No shower sheets for the resident were identified. A three-ring binder that contained paper shower sheets was later provided with no shower sheets for the resident identified. The POC (Point of Care) history report from the EHR, dated 02/21/23 through 04/27/23, was	F 0677	**1:** Resident 26 provided shower per preference. **2:** All residents have the potential to be affected by this alleged deficient practice. DHS or designee will complete an audit of in-house residents to ensure showers are provided per preference and documented appropriately in medical record. **3:** As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on resident shower preference and documentation. DHS or designee will be responsible for auditing residents receiving showers and appropriate documentation. Audit of 5 residents will be conducted 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4. AS a quality measure, the DHS or designees will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted. ="" b="">	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	provided by MDS Support 3 on 04/27/23 at 1:54 P.M. The record indicated the resident had not had a complete bed bath or shower from 04/18/23 to 04/27/23 (nine days). The record indicated the resident received a complete bed bath or a shower on the following dates: - Tuesday, 04/18/23, shower, - Friday, 04/14/23, shower, - Tuesday, 04/04/23, shower, - Friday, 03/31/23, shower, - Wednesday, 03/22/23, complete bed bath, - Tuesday, 03/21/23, complete bed bath, - Friday, 03/17/23, (refused), - Wednesday, 03/15/23, complete bed bath, - Friday, 03/03/23, shower, and - Tuesday, 02/28/23, shower. The resident was admitted on 02/21/23 and did not receive a shower or complete bed bath until seven days later, on 02/28/23. The resident received a shower or complete bed bath ten times. The resident should have been bathed twice a week for a total of 18 times. During an interview on 04/27/23 at 2:34 P.M., QMA (Qualified Medication Aide) 7 indicated if a resident refused a shower the nursing staff were supposed to educate the resident on the importance of bathing and at least encourage them to get a sponge bath. The CNA staff were to report refusals to the nurse or QMA on duty and the refusal should be documented in the Progress Notes. The Progress Notes, from 02/21/23 through 04/27/23, were provided by MDS Support 3 on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	04/27/23 at 3:09 P.M. The record lacked documentation the resident had refused any showers or bathing. During an interview on 04/27/23 at 2:37 P.M., CNA 8 indicated the resident was supposed to be bathed on day shift on Tuesdays and Fridays. During an interview on 04/27/23 at 2:52 P.M., Clinical Support 2 indicated if a resident had not stated a preference, they were bathed twice a week. The "Profile Care Guide" Care Plan was provided by Clinical Support 2 on 04/27/23 at 2:56 P.M. An "Approach" indicated the resident was to be showered on Tuesdays and Fridays on day shift, with a start date of 02/23/23. The current facility policy, titled "Guidelines for Bathing Preference" with a review date of 12/31/22, was provided by Clinical Support 2 on 04/27/23 at 2:46 P.M. The policy indicated, "...Bathing shall occur at least twice a week unless resident preference states otherwise..." The current facility policy, titled "Nursing ADL Documentation Guidelines" with a review date of 12/31/22, was provided by Clinical Support 4 on 04/27/23 at 2:46 P.M. The policy indicated, "To document the type and amount of assistance provided to the resident for activities of daily living...Completion of ADL service will be validated through the use of the CARE ASSIST ADL reports...ADL services will be conducted and documented by the CNA each shift at the [point of care] or as reasonably possible after care..." 3.1-38(a)(2)(A)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow the physician's order related to dressing changes for 1 of 6 residents reviewed for skin conditions (Resident 14) Findings include: During an interview and observation on 04/24/23 at 1:02 P.M., Resident 14 indicated she had been in the hospital for a blood clot on her lung and one by her knee. She had a reaction to a blood thinner and was going to the wound clinic for a wound on her shin area from the reaction to the blood thinner. The record was reviewed on 04/28/23 at 3:16 P.M. A Quarterly MDS (minimum data set) assessment, dated 03/14/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, pulmonary embolism and contusion of the right lower leg. The Care Plan for the resident's venous stasis ulcer to her right lower extremity, with a start date of 04/25/23, was provided by Administrator 9 on 04/28/23 at 3:29 P.M. An intervention, with a start date of 04/25/23, indicated "Treatment per MD	F 0684	**1:** Resident 14's dressing changed and tolerated well. **2:** All like residents have potential to be affected. DHS or designee will complete an audit of in-house residents with dressing change orders to ensure dressing changes are completed per physician order. **3:** As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff dressing change. DHS or designee will be responsible for auditing residents with orders for dressing changes to ensure dressing changes are completed per order. Audit of 5 residents will be conducted 5 times a week times 4 weeks, 2 times a week for 4 weeks, weekly times 1 month, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED.	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	order." The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for April 2023, was provided by MDS Support 3 on 04/28/23 at 10:00 A.M., and included, but was not limited to, the following physician's orders for the resident's right lower leg: - Wound Care: Clean tunnel at 1 o'clock and 11 o'clock daily with saline, pack with normal saline soaked gauze, Hydrofera Blue (a blue antibacterial foam dressing), cover with ABD (Abdominal gauze) pad, Kerlix (gauze wrap), and ace wrap, once a day, with a start date of 04/24/23, a discontinued date of 04/27/23, and a current open-ended order for the same treatment with a start date of 04/27/23. The record lacked documentation that the Hydrofera Blue was ever out of stock or unavailable for use. A dressing change to the resident's right lower leg was observed on 04/27/23 at 4:05 P.M., with LPN (Licensed Practical Nurse) 16. The nurse donned gloves, unwrapped the elastic ace wrap from the right lower leg, removed the Kerlix gauze wrapped around the leg, removed 3 ABD pads that were moist with exudate, then soaked the gauze packing that was directly against the wound to loosen the gauze from the wound bed. The nurse changed gloves, used a swab on a stick to peel back the gauze. The wound bed was red and beefy, had slight bleeding, an undermining pocket toward the knee, and a 3 cm x 0.25 cm strip of yellow slough at the top left of the wound at 10 o'clock. The nurse changed gloves, packed the wound with normal saline soaked gauze, with 2 (4"		4. AS quality measures, the DHS or designees will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The Plan will be reviewed and updated as warranted. **="" b="">**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	x 4") gauze pads in the tunneled area, covered the wound bed with normal saline soaked gauze, covered with the wound with three ABD pads, wrapped the lower leg with Kerlix, then wrapped it with ace bandages. The prescribed Hydrofera Blue was not on the wound when the old dressing was removed, nor was it applied with the new dressing. A dressing change to the resident's right lower leg was observed on 04/28/23 at 1:28 P.M., with the ADON. The nurse gathered supplies, entered the resident's room, placed the supplies on a clean bath towel on the over bed table, then prepared garbage bags for trash and soiled linens. The ADON washed her hands with soap and water, donned gloves, checked for pain, placed a clean towel under resident's right lower leg, unwrapped ace wraps from the leg, then cut and unwrapped the Kerlix gauze wrap that had a moderate amount of brown tinged drainage and a moderate amount of red bloody drainage. The ABD pads were stuck to wound so the nurse soaked them with normal saline to assist in removal. Gauze was exposed that was covering the wound bed. The ADON indicated the Hydrofera Blue should have been on top of the gauze packing the wound bed. She indicated they had run out of the product, and it had been ordered. She had it at the nurse's station and forgotten to bring it in. The nurse removed the gauze that was packed in the top of the wound in the tunneled area, squirted normal saline from a syringe into the area at the top of the wound, cleansed the wound with normal saline soaked gauze, removed her gloves, covered the wound with a towel, used hand sanitizer, and left the room to retrieve the ordered Hydrofera Blue dressing. The nurse returned, opened a package with a long swab, used hand sanitizer, donned gloves, measured the depth of the tunneled area			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	to be 4.5 cm deep, measured the wound, laying the plastic part of the outside of the swab package against the resident's wound, cleaned the tunneled area with normal saline again, opened packages of rolled gauze, rooted through a box of supplies that were on the resident's bed while still wearing her gloves, opened one end of a package of 4" x 4" gauze pads, poured normal saline into the package, then packed the tunneled area at the top of the wound with the soaked gauze. She covered the rest of the wound bed with the Hydrofera Blue foam pad that was approximately 3 1/2" x 5". The nurse covered the top part of the wound with an ABD pad, wrapped the leg with gauze, wrapped the leg with the ace wraps, removed her gloves, and gathered the dirty linens and trash. The Progress Notes for April 2023 were provided by MDS Support 3 on 04/28/23 at 2:04 P.M. The record lacked documentation that any dressing change products were unavailable for use or that the physician or pharmacy had been notified related to the availability of the prescribed treatment. During an interview on 04/25/23 at 3:48 P.M., LPN 10 indicated residents' medications should be available to them within 24 hours. The current "Dressing Changes" policy, with a review date of 12/31/22, was provided by Administrator 9 on 04/28/23 at 2:33 P.M. The policy indicated, "...To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize /control contamination...Follow doctor's recommendations for treatment..." The current "UNAVAILABLE MEDICATIONS"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	policy, with a revised date of "11/18", was provided by MDS Support 3 on 04/28/23 at 10:29 A.M. The policy indicated, "...The facility must make every effort to ensure that mediations are available to meet the needs of each resident...Facility personnel shall:...Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available...If the the facility personnel is unable to obtain a response from the attending physician, the personnel should notify the supervisor and contact the Facility Medial Director for orders and/or direction..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to follow the physicians' orders for the interventions/treatments of pressure ulcers for 2 of 5 residents reviewed for pressure ulcers. (Residents 16 and 31)	F 0686	**1:** Residents 16 and 31 were assessed, physician orders clarified for treatments. **2:** All like residents have the potential to be affected by this	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	Findings include: 1. During an observation on 04/24/23 at 9:12 A.M., Resident 16 was not in her room. A pair of foam boots were lying on her bed. During an observation on 04/24/23 at 9:16 A.M., Resident 16 was sitting in the dining room at a table. Her left foot was resting on the floor with a gripper sock on. Her right foot was resting on her wheelchair foot pedal. During an observation on 04/24/23 at 12:58 P.M., Resident 16 was sitting in the common area with gripper socks in place and both feet were resting on her wheelchair foot pedals. There were no foam boots in place. During an observation on 04/27/23 at 9:22 A.M., Resident 16 was sitting in the common area on the 200 Hall. Her right foot was resting on the wheelchair pedal and her left foot was resting on the floor. There were no foam boots in place. Resident 16's heel wound was observed with the ADON on 04/28/23 at 11:56 A.M., the ADON gathered her supplies, washed her hands, raised the bed up, and donned her gloves. She assisted the resident to turning on her side a little and removed pillows and blankets from atop the resident. A foam boot was removed from the left foot. The ADON indicated the dressing was dated 04/26 and was a Monday, Wednesday, and Friday dressing change. The gauze wrap was removed, and a secured foam bandage dated 04/26 was removed. The old dressing had a moderate amount of drainage. The ADON removed her gloves and washed her hands. The wound was measured by the DON (Director of Nursing) and		alleged deficient practice. An audit of preventative wound measures were conducted and in place. An audit of treatments for all like residents completed with appropriate treatment orders. Licensed nursing staff educated on pressure prevention and treatment orders. **3:** As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the pressure prevention and treatment orders. DHS or designee will be responsible for ensuring wound measurements, treatments and preventative measures in place and completed per order. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4. As quality measure, the DHS or designees will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The plan will be reviewed and updates as warranted. **4:** ="" b="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	was 2 cm in diameter. The wound was covered in 50% slough with granulation tissue present. The area was cleansed with soap and water, then the wound bed was covered with Santyl and gauze. A foam heel pad was put in place and secured with gauze wrap. The resident's foam boot was placed on the foot. During an interview on 04/28/23 at 12:14 P.M., the ADON (Assistant Director of Nursing) provided the treatment order for the resident that indicated the treatment started on 04/22/23 and was supposed to be daily dressing changes. The treatment order was put in the system, on 04/20/23, for Monday, Wednesday, and Friday dressing changes. The record for Resident 16 was reviewed on 04/26/23 at 8:53 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/25/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, malnutrition, and anxiety. The resident required extensive assistance of two or more staff for bed mobility, transfers, and toilet use and required total assistance with bathing. A Progress Note, dated 11/20/22 at 3:45 A.M., indicated the nurse noted a large blister to the left heel on 11/19/22. Skin prep and a foam boot were applied. The nurse observed the blister on 11/20/22 and the blister had burst. The wound was cleansed with normal saline, dried, and a foam dressing was applied. A Facility Wound Management Detail Report, dated 12/08/22, indicated the resident had a Stage 3 pressure ulcer to the left heel. The wound measured 4.3 cm x 4 cm. There was a moderate amount of serosanguineous (pale red to pink, thin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	and watery) exudate. The wound was covered in 100% slough. A Facility Wound Management Detail Report, dated 01/05/23, indicated the resident had a Stage 3 pressure ulcer to the left heel. The wound measured 2.4 cm x 2 cm x 0.2 cm. There was a moderate amount of serosanguineous exudate. The wound was covered in 100% slough. A Facility Wound Management Detail Report, dated 02/02/23, indicated the resident had a Stage 3 pressure ulcer to the left heel. The wound measured 2.1 cm x 2.1 cm x 0.1 cm. There was a light amount of serosanguineous exudate. There was granulation tissue present. A Facility Wound Management Detail Report, dated 03/09/23, indicated the resident had an Unstageable (full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left heel. The wound measured 2 cm x 2.1 cm x 0.1 cm. There was a light amount of serosanguineous exudate. The wound was covered in 50% slough and 50% eschar. A Facility Wound Management Detail Report, dated 04/20/23, indicated the resident had a Stage 3 pressure ulcer to the left heel. The wound measured 1.7 cm x 1.7 cm x 0.3 cm. There was a moderate amount of seropurulant (yellow or tan, cloudy and thick) exudate. The wound was covered in 75% slough and 25% granulation tissue. A Wound Clinic Note, dated 11/22/22, indicated the resident had a Stage 3 pressure ulcer to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	left heel that measured 4.3 cm x 4 cm x 0.1 cm. This was the first noted date of the wound. A Wound Clinic Note, dated 04/20/23, indicated the resident had an Unstageable pressure ulcer to the left heel that measured 1.7 cm x 1.7 cm x 0.3 cm. There was a moderate amount of yellow or brown exudate. The treatment was to cleanse the wound with soap and water, apply Santyl (a wound healing ointment), apply gauze, cover with allevyn, kerlix, and tape. The dressing was to be changed daily for one week. The resident was seen at the wound clinic the following dates for the left heel pressure ulcer: - 11/22/22, - 12/01/22, - 12/15/22, - 12/30/22, - 01/12/23, - 01/19/23, - 01/26/23, - 02/02/23, - 02/13/23, - 02/23/23, - 03/02/23, - 03/09/23, - 03/16/23, - 03/23/23, - 03/30/23, - 04/14/23, and - 04/20/23. The record lacked wound assessments for the following weeks: - 11/22/22- 12/01/22, - 12/16/22 to 12/30/22, - 02/02/23 to 02/13/23, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	- 03/3023 to 04/13/23. During an interview on 04/26/23 at 9:08 A.M., QMA (Qualified Medication Aide) 18 indicated the resident had a wound to her left heel. She wore foam boots to both feet and never refused to put them on. She had been wearing them for a few months. She was supposed to always wear them. During an interview on 04/26/23 at 1:35 P.M., the ADON and DON indicated the resident had admitted to the facility with multiple wounds. The resident had a decline in health and had been refusing care. The resident had a letter of unavoidability that should have been completed and was not. The wound had started on 12/08/22 and the resident had refused care on 12/09/22, 12/11/22, and 12/12/22 that were documented in the progress notes. A wound event had been opened on 11/19/22 and closed 12/15/22. The resident had been wearing foam boots since January. The nurses would assess the resident's skin weekly with showers and all the nursing staff would assess the wound with any care they were providing. They would monitor for redness, swelling, areas turning red and not going away. The staff should have noticed redness or boggy heels before it was a blister. She had started a QA (Quality Assurance) action plan with audits when she first came to the building on 02/14/23. The QA information was provided by the ADON. The QA development and action plan for 02/14/23 listed Resident 16, but nothing had been checked. The record lacked documentation the resident had behaviors prior to the wound developing on 11/19/22. During an interview on 04/26/23 at 2:14 P.M., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	ADON indicated she started a QAPI (Quality Assurance Performance Improvement) on 04/25/23 related to wound measurements as she noticed they had not been getting completed. The QAPI audits were blank. During an interview on 04/27/23 at 11:25 A.M., a Wound Clinic Nurse indicated the resident was to have offloading boots since November and they were to be worn at all times. The resident had started seeing them for the left heel wound in November. She had already been seeing them for other wounds. 2. The record for Resident 31 was reviewed on 04/27/23 at 1:14 P.M. An Admission MDS assessment, dated 02/15/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation, renal insufficiency, wound infection, and a pressure ulcer to the right ankle. The resident was admitted with a Stage 3 pressure ulcer. A Facility Wound Management Report, dated 02/14/23, indicated the resident had a pressure ulcer to the right ankle that was 1.2 cm x 2 cm. There was a light amount of seropurulant exudate. The wound was covered in 100% slough. A Facility Wound Management Report, dated 03/20/23, indicated the resident had a pressure ulcer to the right ankle that measured 1.2 cm x 1.5 cm x 0.2 cm. There was a moderate amount of serosanguineos exudate. The wound was covered in 50% granulation tissue. A Facility Wound Management Report, dated 04/03/23, indicated the resident had a pressure ulcer to the right ankle that measured 1.2 cm x 1.2 cm x 0.1 cm. There was a moderate amount of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	serosanguineos exudate. A Facility Wound Management Report, dated 04/25/23, indicated the resident had a pressure ulcer to the right ankle that measured 1.4 cm x 1.2 cm x 0.1 cm. There was a moderate amount of serosanguineos exudate. A Wound Clinic Note, dated 02/13/23, indicated the resident was seen for a pressure ulcer to the right lateral ankle. The wound measured 1.3 cm x 1.2 cm x 0.2, prior to debriendment. Post debridement the wound measured 1.4 cm x 1.2 cm x 0.2 cm. The treatment plan was to cleanse the area with normal saline, apply Medihoney Calcium Alginate and cover with a boarder foam, three times a week for two weeks. A Wound Clinic Note, dated 02/20/23, indicated the resident was seen for a pressure ulcer to the right lateral ankle. The wound measured 1.1 cm x 1.2 cm x 0.2 cm, prior and post debridement. The treatment plan was to cleanse the area with normal saline, apply Medihoney Calcium Alginate and cover with a boarder foam, three times a week for two weeks. A Wound Clinic Note, dated 03/06/23, indicated the resident was seen for a pressure ulcer to the right lateral ankle. The wound measured 1.1 cm x 1.7 cm x 0.2 cm, prior and post debridement. The treatment plan was to cleanse the area with normal saline, apply Medihoney Calcium Alginate and cover with allevyn life three times a week for two weeks. A Wound Clinic Note, dated 03/20/23, indicated the resident was seen for a pressure ulcer to the right lateral ankle. The wound measured 1.2 cm x 1.5 cm x 0.2 cm, prior and post debridement. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	treatment plan was to start a wound vac. A Wound Clinic Note, dated 03/27/23, indicated the resident was seen for a pressure ulcer to the right lateral ankle. The wound measured 1.2 cm x 1.3 cm x 0.2 cm. The treatment plan was to continue the wound vac. A physician's order, dated 02/14/23 through 03/22/23, indicated the staff were to cleanse the right ankle with normal saline, apply Silver Alginate (a wound absorption ointment), apply a horseshoe callus pad, and cover with a foam dressing. The dressing was to be changed three times a week. The February and March 2023 EMAR/ETAR lacked documentation that the resident had received the Medihoney Calcium Alginate treatment from 02/14/23 through 03/20/23. During an interview on 04/28/23 at 10:15 A.M., a Wound Clinic Nurse indicated they had been seeing the resident for a while for a wound to the right ankle. The resident's right foot has and outward rotation, so it was hard to keep pressure of the ankle. Silver Alginate treatment was used more for absorption and the Medihoney Calcium Alginate worked to cleanse wounds. The wound clinic had orders for the Medihoney to be used in February. The facility should have been using it. The wound clinic would always send an opened tube with the resident when they left their appointment. They had never given verbal orders to the facility to use Silver Alginate instead of Medihoney. During an interview on 04/28/23 at 5:03 P.M., the DON indicated the treatment administered should have been Medihoney and not Silver Alginate.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	The current faciltiy policy titled, "Guidelines for Pressure Prevention" with an effective date of 08/02/2016 and was provided by Clinical Support 4 on 04/27/23 at 2:46 P.M. The policy indicated, "...To maintain good skin intergrity and avoid development of pressure ulcers...inspect the skin daily during care for signs of skin breakdown or changes to the skin. Notify the nurse of changes..." The current facility policy titled, "Guidelines for General Wound and Skin Care" with an approval date of 05/10/2017 was provided by the DON on 04/26/23 at 12:38 P.M. The policy indicated, "...To provide measures that will promote and maintain good skin good skin integrity...Doucment type of wound, location, stage (if applicable), length, width, depth, in centimeters, base, drainage, peri wound tissue, and treatment of the wound weekly...Notify the wound care nurse/nurse supervisor for all new stage II-IV pressure ulcers..." The current facility policy titled, "Pressure/Stasis/Arterial/Diabetic Wound Guidelines" with a review date of 12/31/22, was provided by the DON on 04/26/23 at 12:56 P.M. The policy indicated, "...To provide weekly documentation of wound measurements and condition..." 3.1-40(a)(2)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to appropriately secure a resident's catheter, resulting in an injury of a split and wound to the resident's penis (Resident 46), follow the physician's orders related to catheterization (Resident 46), and the proper positioning of an indwelling urinary catheter drainage bag for a resident that developed a UTI (Resident 28) for 2 of 18 residents reviewed.	F 0690	**1:** Resident 28 wound has healed. **2:** All like residents have the potential to be affected by this alleged deficient practice. An audit of health center residents catheters has been completed with interventions for catheter placement complete. Licensed nursing staff educated on urinary	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	Findings include: 1. During an observation of Resident 46 on 04/26/23 at 2:53 P.M., the ADON (Assistant Director of Nursing) alerted the resident that she was going to observe and cleanse his penis. The resident agreed. The resident's pants and brief were removed. The resident had just had a suprapubic catheter placed. The penis was split from the underneath side of the head down the back side of the shaft. The record for Resident 46 was reviewed on 04/25/23 at 2:29 P.M. An Annual MDS (Minimum Data Set) assessment, dated 03/06/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, diabetes, non-Alzheimer's dementia, UTI (Urinary Tract Infection), and BPH (Benign Prostatic Hyperplasia). The resident required extensive assistance of two or more staff members for transfers, toileting, and bed mobility. A Care Plan, with a start date of 07/21/22, was reviewed on 04/25/23 at 2:29 P.M., the Care Plan indicated the resident used a anchored Foley catheter for a diagnosis of obstructive uropathy, an intervention included, but was not limited to, apply catheter securing device to maintain tubing proper alignment with a start date of 07/21/22. The care plan was reviewed and revised on 04/25/23 at 3:28 P.M. by MDS Support 3, and the intervention was removed, at that time, from the care plan. A Care Plan, dated 03/01/23, indicated the resident had a mechanical injury to the penis from the anchored Foley catheter. An intervention included, but was not limited to, apply a catheter		catheter care. **3:** As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the urinary catheter care. DHS or designee will be responsible for ensuing catheter care is completed and documented in medical record. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. DHS or designee will be responsible for monitoring treatments related to catheter associated skin conditions, as applicable, is completed and documented in medical record. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: Ongoing monitoring will**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	secure device to maintain tubing in proper alignment, with a start date of 04/17/23. A Urology Note, dated 10/25/22, indicated the resident was being seen for urinary retention. The assessment and plan were that the urinary catheter was removed. The resident would unlikely be able to urinate spontaneously but was on maximum medical therapy. The resident had a 30% chance of being able to urinate sitting in the chair with a urinal. They would have the nursing home start in and out catheterization four times daily as that was a lower risk for sepsis than a chronic catheter. The resident would return in one month to see how he had done. The October 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) was provided by the DON on 04/28/23 at 5:03 P.M., and included, but was not limited to, a physician's order dated 10/28/22 through 10/31/22, for "In and Out" Cath (catheterization), three times a day (not four times daily as the urologist specified). The record indicated the in and out catheterization was not administered the following dates and times: - 10/28/22 at 8:15 P.M., the reason was the resident no longer had a catheter, - 10/29/22 at 4:15 A.M., the reason was the resident no longer had a catheter, - 10/29/22 at 1:15 P.M., the reason was the resident had voided that shift, - 10/29/22 at 8:15 P.M., the reason was when the catheter was progressed there was "frank" (evident) blood expelled from the penis around the urethra. There was no urine that progressed into the catheter, - 10/30/22 at 4:15 A.M., the reason was that during the last in and out the resident had blood from the		**continue past 6 months if warranted until 100% compliance met.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	urethra, - 10/30/22 at 1:15 P.M., the reason was the resident voided that shift, and - 10/30/22 at 8:15 P.M., the reason was the resident voided on the toilet. A Progress Note, dated 12/13/23 at 1:03 P.M., indicated the resident had a split in his penis. The resident had previously seen the Urologist, on 11/29/22, and they were aware of the condition. A Facility Wound Management Detail Report, dated 12/13/22, indicated the resident had trauma to the penile shaft that measured 5.2 cm x 2.4 cm. The wound was mucosa area under the penile shaft where the indwelling urinary catheter was inserted. An IDT (Interdisciplinary Team) Progress Note, dated 12/13/23 at 4:03 P.M., indicated the resident had an open area that measured 5.2 cm (centimeters) x (by) 2.4 cm x less than 0.1 cm. The area was dark pink with a small amount of purulent (pus) drainage. The area was cleansed with betadine and a urinary catheter anchor was applied to the right thigh. The RN had notified the urology office related to the split in the penis. The resident had been seen by urology in November and they were aware of the issue. A Wound Clinic Note, dated 01/31/23, indicated the resident had developed destruction to the penis secondary to the catheter. There was nothing to be done to salvage the penis unless he had a suprapubic catheter placed and then would require reconstructive surgery of the penis. At the patient's age and overall health, they did not feel it was a realistic expectation. The actual catheter tubing was somewhat short and the placement of the tube holder on his leg was causing a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	downward traction. The resident had a Stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present. Slough [non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed] and/or eschar [dead tissue] may be visible but does not obscure the depth of tissue loss) pressure ulcer to the penis that had been present for four weeks. The problem was determined to have been caused by a medical device. There was a minimum amount of serous (watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood) and yellow or brown exudate draining from the ulcer. The ulcer bed had exposed subcutaneous tissue. The ulcer was not malodorous. The ulcer boarder was poorly defined. There was 100% granulation tissue with a confluent pattern of pale and beefy red quality. The wound measured 4.3 cm (centimeters) x (by) 1.5 cm x 0.8 cm. The wound treatment was to cleanse daily with normal saline, apply Medihoney (a wound cleansing ointment) , and cover with an absorbent pad placed in the brief or cover with stretch netting. A Wound Clinic Note, dated 02/28/23, indicated the resident had a Stage 3 pressure ulcer to the penis that had been present for 8 weeks. There was a minimum amount of serous exudate draining from the ulcer. The ulcer bed had exposed subcutaneous tissue. The ulcer boarder was poorly defined. There was 100% granulation with a confluent pattern of pale and beefy red quality. The wound measured 4 cm x 1.5 cm x 0.6 cm. The treatment remained the same. The traction on the catheter had been reduced by proper positioning. The penis was unchanged. There was really			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	nothing to be done for this unless the resident or family wanted a suprapubic catheter. The resident was discharged from wound care. The facility lacked any monitoring or assessments for the resident's pressure ulcer to the penis. The only assessments document were the two wound clinic notes. The wound clinic notes indicated the resident's wound was present for four weeks prior to 1/31/23. A Urology Note, dated 03/24/23, indicated the resident's situation was discussed with the resident and his family members. The resident had BPH with obstruction leading to urinary retention associated with his severe deconditioning. The following options were discussed: - 1. In and out catheterization four times daily. This evidently did not work well at the current nursing home. - 2. Chronic Foley catheter with monthly replacement. I was told this does not work well either as they have not been changing his catheter every month. - 3. Suprapubic Tube placement which would require an anesthetic. This would have the advantage of decreasing testicle and prostate infections but not overall number of infections. The penis would not heal. - 4. Trial and void with removal of catheter now that the resident could stand spontaneously. After discussion, option four was chosen. During an interview on 04/26/23 at 9:00 A.M., QMA (Qualified Medication Aide) 18 indicated the resident had a wound to his penis and the penis was split from his indwelling urinary catheter. The resident's catheter had pulled on his penis causing the split. The resident had gone out			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	that day to have a suprapubic catheter placed. During an interview on 04/26/23 at 1:20 P.M., the ADON indicated the resident had a mechanical issue from his catheter and talked to the family about getting a suprapubic catheter. The resident still had a split in the penis, but the wounds were healed. The intervention put into place was for a catheter securement device. If the resident was already care planned for a catheter securing device, then it should have been in place prior to the wounds on 12/13/22. During an interview on 04/27/23 at 9:28 A.M., RN 5 indicated if a resident had an order for in and out catheterization then the nurse would insert a catheter into the resident and remove it when there was no more urine flow. The order should have been followed as it was specified. During an interview on 04/27/23 at 11:21 A.M., a Wound Clinic nurse indicated the resident's catheter was anchored to the leg and that caused a pressure ulcer from the tension of it pulling. The resident's penis had a split and the pressure ulcer was where the catheter laid underneath. The wound had granulation tissue and was a Stage 3. He was seen twice there and discharged due to not being able to continue to do anything for the wound. The resident would have needed a suprapubic catheter to let the wound heal. During an interview on 04/28/23 at 4:14 P.M., the DON indicated the resident's order from urology should have been followed. No policy could be provided for In and Out Catheterization. The current facility policy titled, "Urinary Catheter			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	Care" with a review date of 12/31/22, was provided by Clinical Support 4 on 04/28/23 at 4:18 P.M. The policy indicated, "...Ensure the catheter remains secured. A leg strap may be used to reduce friction and movement at the insertion site..." The current facility policy titled, "Patient with a Foley Catheter", with a revised date of 08/05/22, and provided by Administrator 9 on 04/28/23 at 2:33 P.M. The policy indicated, "...Make sure catheter tubing is secure to leg to avoid any unnecessary pulling on the bladder..." 2. During an observation on 04/24/23 at 1:42 P.M., the resident was sitting in his recliner with the urinary catheter drainage bag hanging on the right side of the chair and resting on the floor. During an observation on 04/26/23 at 4:02 P.M., the resident was sitting in his recliner with the urinary catheter drainage bag hanging on the right side of the chair and resting on the floor. The record for Resident 28 was reviewed on 04/27/233 at 11:06 A.M. An Admission MDS, dated 01/30/233, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, prostate cancer, heart failure, hypertension, diabetes, and renal insufficiency. The resident had had a UTI in the last 30 days and had an indwelling urinary catheter. A physician's order, dated 03/30/23, indicated Tobermycin (an antibiotic) 80 mg (milligrams) to be given intravenously every 12 hours for 6 days, for a UTI. During an interview on 04/28/23 at 2:08 P.M., CNA 12 indicated the catheter drainage bag should be kept lower than the resident's bladder and should			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	never touch the floor. The current facility policy titled, "Urinary Catheter Care" with a review date of 12/31/22, was provided by Clinical Support 4 on 04/27/23 at 4:18 P.M. The policy indicated, "...Be sure the catheter tubing and drainage bag are kept off the floor..." 3.1-18(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to implement recommendations from the RD in a timely manner for 1 of 2 residents reviewed for nutrition. (Resident 1) Findings include:	F 0692	**1:** Resident 1 has been discharged. **2:** All residents have the potential to be affected by this alleged deficient practice. An audit of health center residents has been	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	The record for Resident 1 was reviewed on 04/25/23 at 3:26 P.M. An Admission MDS (Minimum Data Set) assessment, dated 03/20/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, encounter for surgical after care following surgery of the digestive system, malnutrition, gallstone ileus, and partial intestinal obstruction. The resident had episodes of coughing or choking during meals or when swallowing medications and was on a therapeutic diet. The Event Summary List was provided by the ADON (Assistant Director of Nursing) on 04/25/23 at 10:35 A.M. An Event, dated Wednesday 04/12/23, from the RD (Registered Dietician), indicated the resident had a 10 pound weight loss in the past 29 days and Med Pass (a nutritional supplement) was recommended, 90 ml (milliliters), twice a day, for added protein and kcals (kilocalories). The order for the recommended nutritional supplement was not put into place until eight days later on 04/20/23. During an interview on 04/27/23 at 11:03 A.M., the DON (Director of Nursing) indicated the RD came in once a month, reviewed charts, diet orders, weights, and gave recommendations on adding supplements. When the administrative staff had their daily morning meeting, they reviewed the recommendations, orders, Progress Notes, Events, and falls. The recommendations would be reviewed by the NP (Nurse Practitioner). They had a folder they placed the recommendations in for her to review along with any notes or anything they had concerns with. The NP was in the facility		completed to ensure dietician recommendations have been implemented. Licensed nursing staff educated on nutrition recommendation guidelines. **3:** As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on nutrition recommendation guidelines. DHS or designee will be responsible for ensuring nutrition recommendations are addressed and implemented as warranted. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: AS quality measures, the DHS or designees will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The Plan will be reviewed and updates as warranted.** =”” b=””>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	on Monday, Thursday, and Friday. The Medical Director came in on the first Tuesday of every month. The Progress Notes were provided by the DON on 04/27/23 at 11:38 A.M., and included, but were not limited to, the following: - a Note, dated 04/12/23, from the RD indicating the resident had a partial intestinal obstruction, had lost 10 pounds in the past 29 days, and recommended Med Pass 90 ml, twice a day, for added protein and kcals, and - a Note, dated 04/20/23, from the DON, indicating Med Pass 90 ml, twice a day, had been added to the resident's orders. During an interview on 04/27/23 at 11:38 A.M., the DON indicated the recommendation from the RD on 04/12/23 should have been addressed sooner than 04/20/23. The current Nutrition Recommendation Guideline policy with a review date of 12/01/21, was provided by Administrator 9 on 04/27/23 at 3:34 P.M. The policy indicated, "...Dietician completes Nutrition Recommendation...Suggested discipline follows up on recommendation(s) in a timely manner..." 3.1-46(a)(1)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to follow Care Plan interventions following a self-harm allegation for 1 of 5 residents reviewed for unnecessary medications. (Resident 3) Findings include: The clinical record for Resident 3 was reviewed on 04/25/23 at 3:39 P.M. An Annual MDS (Minimum Data Set) assessment, dated 03/12/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, non-Alzheimer's dementia, malnutrition, anxiety, and depression. A Progress Note, dated 03/31/23 at 2:45 P.M., indicated a phone call was received from the resident's daughter. The resident had called her multiple times saying she wanted someone to come and get her and told the daughter she wanted to kill herself. The Social Service Director was talking with the resident and the ADON (Assistant Director of Nursing) was calling psychiatry services. A Progress Note, dated 03/31/23 at 2:47 P.M., indicated the Nurse Practitioner was notified of the resident's comment about wanting to kill herself and 15-minute checks were initiated. A Care Plan, titled "At risk for self-harm including suicide" with a start date of 12/13/20 was reviewed on 04/25/23 at 3:39 P.M. The Care Plan was last	F 0740	**1:** Resident 3 assessed with no adverse effects noted, care plan reviewed and updated. **2:** All residents have the potential to be affected by this alleged deficient practice. An audit of like residents completed and updated as warranted. IDT educated on care plan revision of interventions as appropriate for resident specific interventions. **3:** As a measure of ongoing compliance DHS or designee educated IDT on care plan revision of interventions as appropriate for resident specific interventions. MDSC, SSD or designee will be responsible for ensuring resident specific care plan interventions are appropriate and implemented as warranted. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: As quality measure, the DHS**	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	revised on 03/16/23 and included the following interventions: - start date of 12/13/20, the resident would immediately be placed on 1:1 (one on one) observation and remain on 1:1 until no longer voicing self-harm including, but not limited to, suicidal ideation's with a plan, had been assessed by the physician, and the physician documented in the medical record the resident was safe to be on the campus and not a danger to self or others, -start date of 12/13/20, the resident would immediately be placed on 1:1 and sent to the hospital for evaluation, -start date of 12/13/20, the staff would encourage the resident to communicate feelings, concerns, and fears, -start date of 12/13/20, the staff would observe, record, and report any changes in the resident's mood in the medical record, and -start date of 12/13/20, the staff would remove all objects from the resident's room that pose a risk for self-harm. The clinical record lacked documentation the resident was ever placed on 1:1 observation or sent to the local hospital. During an interview on 04/26/23 at 2:38 P.M., the Social Service Director indicated the nurses had alerted her of the resident's statement. She and the MDS Coordinator had talked with the resident. The resident didn't have a plan to harm herself and was placed on the list to be seen by psychiatric services. It happened on a Friday and the resident was placed on 15-minute checks		**or designees will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The plan will be reviewed and updates as warranted.** =”” b=””>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	through the weekend. She had seen the resident again that Monday and the resident was seen by psych services. During an interview on 04/26/23 at 3:58 P.M., the ADON (Assistant Director of Nursing) and Clinical Support 4 indicated the resident's Care Plan should have been followed or updated related to self-harm to justify the 15-minute checks being completed. The Care Plan for Self-Harm was provided by Administrator 9 on 04/27/23 at 10:35 A.M. The Care Plan was reviewed and revised on 04/26/23 at 4:29 P.M. by the MDS Support and the following interventions were back dated to 03/31/23: - Based on the resident assessment the charge nurse may assign 1:1 supervision (i.e., has a plan and is danger to self) or 15-minute checks (i.e., if safe to remain in the campus and was not a danger to self) to ensure the resident's safety, and - Notify the psych provider as needed. The current facility policy titled, "Comprehensive Care Plan Guidelines", with a review date of 12/31/22, was provided by Administrator 9 on 04/27/23 at 10:35 A.M. The policy indicated, "...To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines...Comprehensive care plans need to remain accurate and current..." 3.1-43(a)(1)			
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
Bldg. 00	Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to have medications available for 2 of 18 residents reviewed for pharmacy services. (Residents 16 and 1) Findings include:	F 0755	**1:** Resident 1 has been discharged. Resident 16 assessed for pain without findings. **2:** All residents have the potential to be affected by this alleged deficient practice. An audit of like	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	1. The record for Resident 16 was reviewed on 04/26/23 at 8:53 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/25/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, malnutrition, and anxiety. The resident required extensive assistance of two or more staff for bed mobility, transfers, and toilet use and required total assistance with bathing. An open-ended physician's order with a start date of 12/02/22, indicated the resident was to receive pregabalin (a nerve medication), 75 mg (milligrams), three times a day. The April 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident did not receive the medication on the following dates and times: - 04/04/23 from 11:00 A.M. to 1:30 P.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/05/23 from 11:00 A.M. to 1:30 P.M. due to the drug being unavailable, - 04/06/23 from 6:00 A.M. to 10:00 A.M., P.M. and 11:00 A.M. to 1:30 P.M. due to the drug being unavailable, - 04/07/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/08/23 from 6:00 A.M. to 10:00 A.M. due to the drug being unavailable, - 04/09/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/10/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due		residents completed with no additional findings. Licensed nursing staff educated on physician notification. **3:** As a measure of ongoing compliance DHS or designee educated Licensed nursing staff educated on physician notification. DHS or designee will be responsible for ensuring resident medications are administered and recorded as ordered. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: As a quality measure, the DHS or designees will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The plan will be reviewed and updated warranted. ="" b="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	to the drug being unavailable, - 04/11/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/12/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/13/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/14/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/15/23 from 6:00 A.M. to 10:00 A.M. and 11:00 A.M. to 1:30 P.M. due to the drug being unavailable, - 04/16/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/17/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/18/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/19/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/20/23 from 6:00 A.M. to 10:00 A.M. and 11:00 A.M. to 1:30 P.M. due to the drug being unavailable, - 04/22/23 from 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 1:30 P.M., and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, and - 04/23/23 from 6:00 A.M. to 10:00 A.M., and 11:00 A.M. to 1:30 P.M. due to the drug being unavailable. The record lacked documentation that the physician was notified of the medication being			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	unavailable. During an interview on 04/28/23 at 3:47 P.M., QMA (Qualified Medication Aide) 18 indicated the pregabalin medication was not available in the EDK (Emergency Drug Kit). If the medication was signed off and not available, then it was signed off when it should not have been. An open-ended physician's order with a start date of 11/01/22, indicated the resident was to receive pantoprazole (a reflux medication) 40 mg, twice a day. The April 2023 EMAR/ETAR indicated the resident did not receive the medication on the following dates and times: - 04/06/23 from 6:00 A.M. to 10:00 A.M. due to the drug being unavailable, - 04/09/23 from 6:00 A.M. to 10:00 A.M. due to the drug being unavailable, - 04/13/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/14/23 from 6:00 A.M. to 10:00 A.M. due to the drug being unavailable, - 04/17/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/18/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/19/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, - 04/20/23 from 6:00 A.M. to 10:00 A.M. due to the drug being unavailable, - 04/21/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	unavailable, - 04/22/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable, and - 04/24/23 from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. due to the drug being unavailable. The record lacked documentation that the physician was notified of the medication being unavailable. During an interview in 04/26/23 at 9:00 A.M., QMA 18 indicated if a resident's medication was unavailable, she would check the EDK first, if it wasn't available there, she would mark the medication as unavailable and call the pharmacy. They would let her know when the medication was coming. The medication should be delivered that night or the next day. The physician should be notified if a medication was not administered and documented in a progress note. During an interview on 04/28/23 at 4:08 P.M., the DON (Director of Nursing) indicated she had talked to the pharmacy about the resident's medications being unavailable. The resident was private pay with Medicaid pending. She was waiting for the family to say they were going to pay for the medication or if they were going to provide it. The physician was notified but she wasn't sure where it was documented. During an interview on 04/28/23 at 5:36 P.M., the DON indicated she could not provide any documentation that the physician was notified of the medications being unavailable.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	2. During an interview on 04/26/23 at 9:44 A.M., Resident 1 was awake and sitting in her recliner in her room. She indicated she had come to the facility after having surgery for a blocked bowel. She had been in the hospital for seven days. Her pain when she first got here was about an 8 out of 10. She was taking something stronger than Tylenol after her surgery and it had helped. During an interview on 04/25/23 at 3:44 P.M., RN 19 indicated when a resident came from the hospital the nurse on the floor would get a report from the sending facility. The admitting nurse on the floor put the physician's orders that come from the hospital in the computer. During an interview on 04/25/23 at 3:48 P.M., LPN 10 indicated when a resident was admitted from a hospital, the hospital discharge orders would say what medications they had received at the hospital, what orders to continue, and what orders to stop. They had an EDK they could get medications from or they could order the medications immediately, and they could have them in an hour or so. The resident's medications should be available to them within 24 hours. The resident had gall stones that had passed into her digestive system and had formed a bowel blockage. The hospital did a bowel resection, took out her gallbladder, and repaired an umbilical hernia. She was in quite a bit of pain when she arrived to the facility. The record was reviewed on 04/25/23 at 3:26 P.M. An Admission MDS assessment, dated 03/20/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, encounter for surgical after care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	following surgery of the digestive system, malnutrition, gallstone ileus, and partial intestinal obstruction. The resident received pain medication as needed, and frequently had pain. T The hospital Discharge Summary, dated 03/14/23 at 1:28 P.M., was provided by the DON on 04/28/23 at 9:20 A.M. The record indicated the resident had a physician's order for Tramadol (a pain medication) 50 mg, every eight hours as needed. The Event Summary List was provided by the ADON (Assistant Director of Nursing) on 04/25/23 at 10:35 A.M. A Pharmacy Recommendation Event, dated 03/17/23 at 11:42 A.M., indicated the pharmacist had reviewed the medication regime and additional admission documentation had not been linked to the electronic heath record at that time related to the hospital discharge medication list. The Progress Notes were provided by the DON on 04/27/23 at 11:38 A.M. The Note, dated 03/17/23 at 9:30 P.M., indicated the resident had complained of a moderate amount of pain. The nurse attempted to give her Tramadol 50 mg, which was on her MAR (Medication Administration Record), to be given as needed. There was no Tramadol in the narcotics drawer. The nurse called the pharmacy and they indicated they had never received a prescription for Tramadol. The nurse attempted to call the MD who was on call. The On Call MD declined to call in a prescription. The nurse called the DON and the DON stated if the On Call MD would not give a prescription, the NP (Nurse Practitioner) would send one the next day and to please contact the NP to make sure the prescription for the Tramadol was sent in the next day.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	The EMAR/ETAR for March 2023, was provided by MDS Support 3 on 04/28/23 at 10:29 A.M., and included, but was not limited to, the following open-ended physician's order: - Tramadol 50 mg, every eight hours as needed for moderate pain, with a start date of 03/14/23. The record indicated the resident had abdominal pain rated 8 out of 10, on 03/17/23, at 9:02 P.M. The medication was not administered because there was no prescription on file per the pharmacy. The resident had complained of pain on 03/18/23 at 2:40 A.M., and the medication was not given. The resident was not given the prescribed medication until 03/22/23 at 8:09 A.M., for back pain rated 7 out of 10, nine days after the resident was admitted to the facility. The EDK was observed with QMA 11 on 04/28/23 at 2:53 P.M. Tramadol was available in the EDK. The current "UNAVAILABLE MEDICATIONS" policy, with a revised date of "11/18", was provided by MDS Support 3 on 04/28/23 at 10:29 A.M. The policy indicated, "...The facility must make every effort to ensure that mediations are available to meet the needs of each resident...Facility personnel shall:...Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available...If the facility personnel is unable to obtain a response from the attending physician, the personnel should notify the supervisor and contact the Facility Medial Director for orders and/or direction..." 3.1-25(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to prevent a significant medication error related to Coumadin (a blood thinner) for 1 of 18 residents reviewed. (Resident 31) Findings include: During an observation on 04/26/23 at 2:37 P.M., Resident 31 was sitting in his room. The resident had a visitor, and the call light was within reach. There were no concerns noted. The clinical record for the resident was reviewed on 04/27/23 at 1:14 P.M. An Admission MDS (Minimum Data Set) assessment, dated 02/15/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation, renal insufficiency, wound infection, and a pressure ulcer to the right ankle. A Progress Note, dated 04/18/23 at 8:30 A.M., indicated the resident's blood test for INR (International Normalized Ratio) was 1.1, and the PT (Prothrombin Time) was 12.9. The physician was notified. A Progress Note, date 04/18/23 at 6:31 P.M., indicated the physician called the facility and was asking why the residents INR level was dropping instead of rising. Upon looking into the resident's medication orders it was determined that the residents Coumadin medication was stopped too early. New orders were received to start Lovenox (an injection blood thinner) 40 mg (milligrams),	F 0760	**1:** Resident 31 has discharged. **2:** All like residents have the potential to be affected by this alleged deficient practice. An audit of like residents with coumadin completed with no additional findings. Licensed nursing staff physician order transcription. **3:** As a measure of ongoing compliance DHS or designee educated Licensed nursing staff educated on physician order transcription. DHS or designee will be responsible for ensuring resident medications transcribed appropriately in the residents medical record. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. ="" b="">"> **4. As quality measures, the DHS and designees will review any findings and corrective action at least quarterly and ongoing until campus achieves**	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	twice a day, until 04/22/23. All appropriate parties were notified. During an interview on 04/28/23 at 11:08 A.M., LPN (Licensed Practical Nurse) 15 indicated the nurses obtained the residents' PT/INR levels in the facility by using a finger stick method. Resident 31's results would get faxed to the Coumadin Clinic. The medication should be administer as ordered. She had been the nurse working the day it was discovered the resident's Coumadin had not been given. She obtained the level and faxed it to the clinic. The clinic had called and asked why the resident's levels were dropping. She started looking into it and the resident had been being prepped for vascular surgery and the order was transcribed wrong. The physician had ordered Lovenox. The resident did not have to go to the hospital nor had they suffered any complications from not receiving the Coumadin. His vital signs had remained stable and he had no bleeding or bruising concern. During an interview on 04/28/23 at 2:34 P.M., the ADON (Assistant Director of Nursing) indicated a nurse had notified her that a resident's INR level was off. There had been a transcription error with the medication. The resident was scheduled for surgery on 4/26/23 and the resident's Coumadin was to be held on 04/21/23, before surgery. A nurse had transcribed the order wrong and didn't change the date when it was supposed to be held. The resident had not received the Coumadin dose starting from 04/12/23 instead of 04/21/23. Since the resident had not received his Coumadin on 04/12/23 through 04/19/23 the physician ordered Lovenox to be administer instead of the Coumadin, to increase the resident's IN. The resident Commanding order from 04/12/23		**100% compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	through 04/19/23, was to receive 2 mg on Mondays and Fridays and 3 mg all other days. The current facility policy titled, "Anti-Coagulation Assessment Guideline" with a review date of 12/31/22, was provided by Administrator 9 on 04/28/23 at 2:33 P.M. The policy indicated, "...to provide guidelines for monitoring residents on anticoagulant therapy...Residents receiving Commanding will have labs ordered by the physician to monitor & adjust dosing...For residents receiving Commanding, most recent Commanding lab will be reviewed prior to administering Commanding. The nurse will ensure that an order is in place for the next Commanding lab..." The current facility policy titled, "Guidelines for Medication Orders", with a review date of 12/31/22, was provided by Clinical Support 4 on 04/27/23 at 2:46 P.M. The policy indicated, "...To establish guidelines in the receiving and recording of medication orders..." 3.1-48(ac)(2)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to follow a physician's order related to obtaining laboratory test for 1 of 18 residents	F 0770	**1:** Resident 15 labs ordered and completed. **2:** All residents have the potential	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	reviewed. (Resident 15) Findings included: The record for Resident 15 was reviewed on 04/27/23 at 10:15 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/23/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertensive heart and chronic kidney disease with heart failure, hypertension, renal insufficiency, diabetes, non-Alzheimer's dementia, malnutrition, and depression. A Psychiatry Progress Note, dated 11/08/22, indicated the resident had a GFR (Glomerular Filtration Rate), a kidney function level, of 31. The resident's Cymbalta (a depression medication) was discontinued, and they were started on Effexor (a depression medication). A BMP (Basic Metabolic Panel) lab (laboratory test) was to be checked in two weeks. A Psychiatry Progress Note, dated 12/08/22, indicated the resident was to continue the Effexor medication and to obtain a BMP level. The record lacked documentation the BMP level was obtained from 11/08/22 through 12/10/22. During an interview on 04/27/23 at 2:16 P.M., RN 5 indicated when a physician ordered labs the nurse would input an ancillary order. The labs would be obtained the same evening on second or third shift and picked up by the pharmacy. The results would be available within 24 to 72 hours. Once the results were received, they would be sent to the ordering physician. During an interview on 04/28/23 at 10:27 A.M., the		to be affected by this alleged deficient practice. An audit labs has been completed with no additional findings. Licensed staff educated on lab draw process and result monitoring. **3:** As a measure of ongoing compliance DHS or designee educated Licensed nursing staff lab draw process and results monitoring. DHS or designee will be responsible for ensuring lab orders are drawn and resulted timely. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: As a quality measure, the DHS or designees will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The Plan will be reviewed and updated as warranted.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	DON (Director of Nursing) indicated the resident's lab order for November got missed and should have been completed. No policy was provided for obtaining labs. 3.1-49(a)			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on interview and record review, the facility failed to demonstrate that ongoing corrective actions were in place to address a significant medication error related to Coumadin for 1 of 18 residents reviewed. (Resident 31) Findings include: The current "Quality Assessment and Assurance Committee Action Plan" was provided by Administrator 17 on 04/25/23. The plan indicated, "...Action Item/Intervention...Responsible Party...Target Date..." During the Annual Recertification and Complaint survey, from 04/24/23 to 04/28/23, F760 was cited. The facility's Quality Assurance Committee did not implement on-going appropriate measures to correct identified issues or prevent deficiencies as follows: 1. Significant Medication Errors: One resident experienced a significant medication error when his Coumadin medication was not administered. During an interview on 04/28/23 at 2:34 P.M., the ADON (Assistant Director of Nursing) indicated	F 0867	**1:** Resident 31 has discharged. **2:** No residents were affected by this alleged deficient practice. An audit of QAPI action plans were completed and updated as warranted. IDT educated on QAPI action plans and monitoring systemic processes. **3:** As a measure of ongoing compliance ED or designee educated IDT to ensure QAPI action plans are completed and updated as warranted. The ED or designee will be responsible for ensuring QAPI meetings are held per policy and action plans updated appropriately. Audit of QAPI meeting plans will be completed weekly times 8 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: As quality measure, the DHS or designees will review any findings and corrective action**	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	she started a Quality Assurance related to residents on Coumadin. The nurses must have a second nurse verify the order and next date for the PT/INR (Prothrombin Time/International Normalized Ratio.) She had completed an audit of all the orders to ensure everyone had Coumadin orders and PT/INR dates. The management team had a meeting daily, Monday through Friday, and she would go through all the orders to make sure no Coumadin orders were missed and that the documentation was there as a daily audit. She educated the nurse that had the medication error verbally but did not document it anywhere. All the nurses had received education on verification of two nurses for Coumadin orders. There was no education specific to medication errors with Coumadin. The QA (Quality Assurance) was ongoing daily. Her initial audits were in a box under her desk and not with the other ongoing QA records. The Quality Assessment and Assurance Committee Action Plan indicated the Action Plan was for Medication Errors. The goal was for no Coumadin errors. The Action Item/Intervention included the following: - 1. Review all like residents for potential for medication errors, with a target date of 04/20/23, - 2. Educate nursing on Coumadin errors- two nurses to verify that order was correctly entered in the EMAR (Electronic Medication Administration Record), with a target date of 04/20/23, and - 3. Review Coumadin orders during CCM (morning meetings) for errors, with an ongoing target date. The Survey POC Audit Tool, dated April 2023, indicated the audits were completed on 04/20/23		**at least quarterly and ongoing until campus achieves 100% compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted.** =”” b=””>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	and 04/25/23. The nurse education, dated 04/20/23, indicated all Coumadin orders must be verified by a second nurse and needed to chart in a progress note that it was verified. The nursing education lacked any education related to medication errors with Coumadin. A Progress Note for Resident 31, dated 04/27/23 at 11:19 A.M., indicated a PT/INR was completed in house and the results were sent to the physician for verification on previous Coumadin orders to restart. The nurse was waiting for a response. There were no other notes indicating the residents Coumadin order was verified by two nurses on 04/27/23 or that a new PT/INR order was obtained. The April 2023 EMAR/ETAR (Electronic Treatment Administration Record) for Resident 31 indicated the resident was administered Coumadin 3 mg (milligrams) on 04/27/23. During an interview on 04/28/23 at 2:58 P.M., Clinical Support 4 indicated she had told them to have written education on Friday 04/20/23 and it should have been done. During an interview on 04/28/23 at 3:13 P.M., Clinical Support 4 indicated the education for verification of two nurses should have been followed. Cross Reference F760.			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	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 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,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	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. 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 interview, record review, and observation, the facility failed to follow appropriate infection control guidelines for 1 of 6 residents reviewed for wound care (Resident 47), and for 1 of 2 residents reviewed for urinary catheter care. (Resident 38) Findings include: 1. During an interview on 04/24/23 at 10:46 A.M., Resident 47 indicated he had been in a hospital	F 0880	**1:** All like residents were assessed by DHS/Designee for adverse affects of nurse not washing hands between removing gloves from old to new dressing and staff not wearing gloves while emptying foley catheter into graduated cylinder. **2:** The facility QAA Committee conducted a root cause analysis to identify the problem(s) that	05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	last year and had a wound on his backside since that time. The staff in the facility changed the dressing twice a day or whatever the wound clinic prescribed. He went to the wound clinic every week or two. The record was reviewed on 04/28/23 at 10:56 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/28/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, traumatic spinal cord dysfunction and pressure ulcer of the sacral region. The resident had one unhealed stage 4 (bone and/or tendon visible) pressure ulcer that was present on admission. The dressing change to the resident's pressure ulcer of the sacral region was observed on 04/26/23 at 12:59 P.M., with LPN (Licensed Practical Nurse) 10. The nurse gathered supplies, placed them on the over the bed table, and had the resident roll onto his left side. The nurse washed her hands, donned clean gloves, removed the old dressing that had a moderate amount of drainage, then removed her gloves. The nurse donned clean gloves, sprayed the wound with wound cleanser, wiped the inside of the wound with a gauze pad, touched the call light button on the wall with her gloved hand to cancel it, continued using both hands for the dressing change procedure, applied Skin Prep (a skin toughening agent) around the perimeter of the wound, dusted the outside edges of the wound with Nystatin powder (an antifungal medication), folded two small square sheets (approximately 1-1/2" (inches) of Adaptic (a non-adhering dressing designed to minimize the pooling of fluid at the wound site) and applied them inside the wound to the exposed bone, packed the wound with silver alginate, covered it with a 4" x (by) 4"		resulted in the indicated infection control deficiency regarding PPE use in a room with TBP. This RCA was completed on 05/19/22 by the QAA Committee. The QAA Committee developed an action plan to prevent recurrence as part of the QAPI program. The root cause of the indicated deficiencies was determined by the QAA Committee to be lack of continued ongoing education regarding Donning and doffing gloves and proper hand hygiene during dressing changes. The DHS/Designee provided training to staff providing direct care to residents. The training included Standard infection control practices; Transmission based Precautions. and the appropriate use of PPE while caring for wounds and catheters. **3:** To assure ongoing compliance the Director of Health Services in conjunction with the QAA Committee will conduct weekly audits in which the DHS/Designee will visually observe staff members to ensure they are donning and doffing gloves appropriately for emptying catheters and during dressing changes. These audits will be completed weekly for 5 weeks then randomly thereafter up to 6 months. **4: AS quality measure, the DHS or designees will review any findings and corrective action at least quarterly and ongoing**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	gauze pad, then an ABD (Abdominal) gauze pad, then with an island dressing. The nurse removed her gloves and dated the dressing. The nurse indicated on admission the wound was as big as your fist. The wound was observed to be about the size of a golf ball with measurable depth. During an interview on 04/28/23 at 2:16 P.M., Clinical Support 4 and the ADON (Assistant Director of Nursing) indicated during a dressing change, clean technique was to be followed. Things were not sterile, but you do not contaminate, and dressing change products should be kept on a clean field. Staff should not be touching inanimate items outside of the clean field. The current "Dressing Changes" policy, with a review date of 12/31/22, was provided by Administrator 9 on 04/28/23 at 2:33 P.M. The policy indicated, "...To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize /control contamination..." 2. During an observation on 04/24/23 at 1:17 P.M., CNA (Certified Nurse Aide) 13 placed a graduated cylinder on the end of the resident's bed. She held the urinary catheter drainage bag with an ungloved hand above the graduated cylinder and above the resident's bladder. She removed the drainage tube from the holder on the urinary drainage bag with her gloved left hand, unclamped the tube, and emptied the urine from the urinary drainage bag. She closed the clamp on the tube, placed it back in the holder on the side of the urinary drainage bag, and hung the urinary drainage bag on the side of the bed. She measured the urine, took the graduated cylinder to the bathroom, emptied it in the toilet, and rinsed the graduated cylinder.		**until campus achieves 100% compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted.** =”” b=””>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	The clinical record for Resident 38 was reviewed on 04/26/23 at 1:36 P.M. An Annual MDS assessment, dated 01/21/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, stroke, and neurogenic bladder. The resident had an indwelling urinary catheter. During an interview on 04/28/23 at 2:08 P.M., CNA 12 indicated she would always wear gloves and would never place a urinal or graduated cylinder on a resident's bed to empty the catheter drainage bag. The catheter drainage bag should be kept lower than the resident's bladder. The current facility policy titled, "Emptying Urinary Bag " with a review date of 12/31/22, was provided by Clinical Support 2 on 04/28/23 at 2:38 P.M. The policy indicated, "...keep the drainage bag below the level of the resident's bladder...wash and dry hands thoroughly...put on disposable gloves..." 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00403652. Complaint IN00403652 - No deficiencies related to the allegations are cited. Survey dates: April 24, 25, 26, 27, and 28, 2023 Facility number: 012854	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	Residential Census: 19 Aspen Place Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on May 8, 2023.		to the allegation of noncompliance cited during Annual survey conducted on April 28, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 19, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	