PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVI	CES	
CENTERS FOR MEDICARE & MEDICAID SERVI	CES	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	A. BUILDING COMPL		DATE SURVEY DMPLETED	
		155797	B. WI	B. WING		05/16/	2023
	ROVIDER OR SUPPLIER			2320 N	ADDRESS, CITY, STATE, ZIP COD MONTGOMERY ROAD ISBURG, IN 47240		
ASPENE	LACE HEALTH CA	INF 03		GREEN	13BUNG, IN 47240	,	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
E 0000							
Bldg	REGULATORY OR LSC IDENTIFYING INFORMATION 0		E 00	000	May 31, 2023 Submission of this Plan of Correction does not indicate a admission by Aspen Place He Campus that the findings and allegations contained herein a accurate and true representati of the quality of care and servi provided to the residents of As Place Health Campus. This facility recognized it's obligation provide legally and medically necessary care and services to residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this profice of correction shall serve as the credible allegation of compliant with all state and federal	alth re ons ces spen on to o its e or	
					requirements governing the management of this facility. It thus submitted as a matter of statute only. We respectfully request paper review for this p of correction. If you need any information of paperwork, please do not hesi	olan	
					to contact us at (812) 527-222		

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

TITLE

(X6) DATE

Kellee Couch **Executive Director** 06/01/2023 Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/16/2023
NAME OF PROVIDER OF		STREET ADDRESS, CIT 2320 N MONTGON GREENSBURG, IN	MERY ROAD
PREFIX (EACI	UMMARY STATEMENT OF DEFICIENCIE DEFICIENCY MUST BE PRECEDED BY FUL ATORY OR LSC IDENTIFYING INFORMATION	PREFIX (EACH COI CROSS-REF	VIDER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) DATE CX5 COMPLETION DATE
K 0000		Kellee Co	ouch, Executive Director
Licensured Department 483.90(a) Survey D Facility N Provider AIM Nur At this Lithealth Canada Requirem Medicare Life Safe National Life Safe Health Canada Reaction Corridors resident sof the facility detection corridors resident sof the facility of th	fety Code Recertification and State Survey was conducted by the Indiana int of Health in accordance with 42 CFR ate: 05/16/23 umber: 012854 Number: 155797 uber: 201104690 fe Safety Code survey, Aspen Place interest for Participation in Medicaid, 42 CFR Subpart 483.90(a), y from Fire and the 2012 edition of the Fire Protection Association (NFPA) 10 y Code (LSC), Chapter 19, Existing re Occupancies and 410 IAC 16.2. Story facility was determined to be of 11) construction and fully sprinkled. The health are portion lity has a fire alarm system with smoke in the corridors, spaces open to the and hard wired smoke detectors in all the ping rooms. The healthcare portion lity has a capacity of 64 and had a 61 at the time of this visit. Where residents have customary access and lareas providing facility were sprinklered. eview completed on 05/17/23	Correction admission Campus to allegation accurate a of the quater provided of Place Heat facility receptor provide less necessary residents efficient in hereby manufacture accomprehe facilities (programs of correct credible a with all starequirement management thus subnivature or request profice correct.	on of this Plan of In does not indicate an In by Aspen Place Health Ithat the findings and It is contained herein are It is and true representations It is of care and services It is to the residents of Aspen It is all the campus. This It is cognized it's obligation to It is an economic and It is in an economic and It is in an economic and It is in all compliance with the It is of participation for It is ensive health care It is of Title 18/19 It is in an economic and the interest of participation for It is ensive health care It is of participation for ensive health care It is of participation for ensive health care It is on shall serve as the It is end, this plan It is end, this plan It is end federal It is ents governing the In ent of this facility. It is It is in it is in in it is in in it is in it is in it is in in it is in it is in it is in it is in it is in in it is in it is in in it is i

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Event ID:

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED	
		155797	B. WING		05/16/2023
	PLACE HEALTH CA		2320 N	ADDRESS, CITY, STATE, ZIP COD MONTGOMERY ROAD NSBURG, IN 47240	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exit discharge is a 7.7, provides a level the provisions of 7 changes in elevating free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure 1 of level walking surface and constructed of 1 surface in accordance Certification Letter could affect 12 resides Findings include: Based on observation Director of Plant Operations of Plant Operations and 1:45 p.m., the exit door, near RR 3 concrete and was unseparation created a Plant Operations and was in need of repair walking surface that leading to the communication.	cits cits cits citranged in accordance with rel walking surface meeting r.1.7 with respect to on and shall be maintained s. Additionally, the exit a hard packed all-weather on and interview, the facility rel over 4 exit discharges had a see, were free of obstructions, hard packed all-weather travel see with CMS Survey and ob-38. This deficient practice dents and staff on the 300 hall. ons and interview with the perations and Facilities Support 5/16/23 between 11:45 a.m. xit discharge from the 300 Hall standard a large crack in the neven and the rise in trip hazard. The Director of knowledged that the walkway in to have a complete level t was free of trip hazards non way.	K 0271	Sincerely, Kellee Couch, Executive Direct The Director of Plant Operation ground down the uneven the cracked uneven concrete so t both sides of the crack were le with each other. He then filled crack with a self-leveling conc crack filler. The Director of Plant Operation was educated by the Executive Director on K 271 – Discharge from Exits. Exit discharge is arranged in accordance with 7 provides a level walking surfa meeting the provisions of 7.1. with respect to changes in elevation and shall be maintain free of obstructions. Additionat the exit discharge shall be a h packed all weather travel surfa 18.2.7, 19.2.7 The Director of Plant Operation	ons 05/24/2023 hat evel ons //e e 7.7, ce 7 ined ally, hard ace.
		knowledged by the Director of the time of discovery and		will inspect exit discharge for uneven concrete 1 x week for	1

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again by the Director of Plant Operations and

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month and 1 x a month for 3

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155797	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 6/2023
	PROVIDER OR SUPPLIEF		2320 N	ADDRESS, CITY, STATE, ZIP C I MONTGOMERY ROAD NSBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
K 0920 SS=D	conference. 3.1-19(b) NFPA 101	epresentative at the exit		months. Results of these inspector be presented by Execut Director to the QA comfurther recommendation continue until the Qual Assurance Team deter substantial compliance achieved. The deficient practice of 12 residents and staff hall. Exhibit A- Discharge from the process of	ative nmittee for ons and ity rmines has been could affect on the 300 om exit	
Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not use	ent - Power Cords and ent - Power Strips and electrical equipment des that have been elified personnel and meet elified personnel and mee				

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> B. WING		COMPLETED 05/16/2023	
		155797	B. W.	B. WING		05/16/	72023
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
ASPEN PLACE HEALTH CAMPUS				MONTGOMERY ROAD ISBURG, IN 47240			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		moved immediately upon					
	· ·	purpose for which it was the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
		(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	K 0	920	The Director of Plant Operatio	ns	05/16/2023
		f 1 resident rooms did not used	110	20	removed and disposed of the		03/10/2023
		as a substitute for fixed			multi-plug adaptor from room	216	
		equires electrical wiring and			and installed a hard wired hos		
	equipment shall be	in accordance with NFPA 70,			grade quad outlet in place of t	he	
	National Electrical	Code. NFPA 70, 2011 Edition,			hard wired duplex outlet.		
	-	res that, unless specifically			The Director of Plant Operatio		
	permitted, flexible cords and cables shall not be				was educated by the Executiv	е	
	used as a substitute for fixed wiring of a structure.				Director on K 920 – Electrical		
	This deficient practice affects 1 resident.				Equipment – Power Cords and	d	
	TO 12 1 1 1				Extension Cords.		
	Findings include:				Power strips in a pati	ent	
	Dagad on abaamiati	ons and interview with the			care vicinity are only used for	_4	
		perations and Facilities Support			components of movable patient care related electrical equipments		
	· ·	05/16/23 between 11:45 a.m.			(PCREE) assembles that have		
	-	dent Room #216 contained a			been assembled by qualified	-	
	-	powering electronic equipment.			personnel and meet the condi	tions	
		at the time of observation, the			of 10.2.3.6. Power strips in th		
		perations agreed a mulita-plug			patient care vicinity may not be		
	adaptor was in use				used for non-PCREE (e.g.,		
					personal electronics), except i	n	
	This finding was ac	knowledged by the Director of			long-term care resident rooms	that	
	-	the time of discovery and			do not use PCREE. Power str	ips	
		or of Plant Operations and			for PCREE meet UL 1363A or	UL	
Facilities Support Representative at the exit				60601-1. Power strips for			
	conference.				non-PCREE in the patient care		
	2.1.10(1)				rooms (outside of vicinity) mee		
	3.1-19(b)				1363. In non-patient care room	ns,	
					power strips meet other UL		
					standards. All power strips are used with general precautions		
					Extension cords are not used		
					substitute for fixed wiring of a	us a	
					structure. Extension cords use	ed	
			1			-	

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	MEDICARE & MEDI						IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPI	LETED
155797		B. WING			05/16	/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIE	ER					
AODENIE	N AOE HEALTH O	AMPLIC			MONTGOMERY ROAD		
ASPEN F	PLACE HEALTH C	AMPUS		GREEN	NSBURG, IN 47240		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	MATE	DATE
					temporarily are removed		
					immediately upon completic	on of	
					the purpose for which it was		
					installed and meet the cond		
					of 10.2.4, 10.2.3.6 (NFPA 9	9),	
					10.2.4 (NFPA 99), 400-8 (N	FPA	
					70), 590.3(D) (NFPA 70).		
					The Director of Plant Opera	tions	
					will inspect for the use of		
					multi-plug adaptors 1 x wee	k for 1	
					month and 1 x a month for		
					months.		
					Results of these inspections	s will	
					be presented by Executive		
					Director to the QA committee	e for	
					further recommendations a	nd	
					continue until the Quality		
					Assurance Team determine	s	
					substantial compliance has	been	
					achieved.		
					The deficient practice could	affect	
					1 resident.		
					Exhibit A – Electrical Equip	ment –	
					Power & Extension cord au		
					Exhibit B – Photos and other		
					documentation.		

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