STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155797	B. Wl	NG		05/13/	2025
	PROVIDER OR SUPPLIER		<u> </u>	2320 N	ADDRESS, CITY, STATE, ZIP COD MONTGOMERY ROAD ISBURG, IN 47240		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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Bldg. 00	Licensure Survey. T Residential Licensur Survey dates: May 6 Facility number: 01 Provider number: 13 AIM number: 2011 Census Bed Type SNF/NF: 34 SNF: 6 Residential: 27 Total: 67 Census Payor Type: Medicare: 3 Medicaid: 25 Other: 12 Total: 40 These deficiencies r accordance with 416	5, 7, 8, 9, 12 and 13, 2025. 2854 55797 04690	F 00	000	This submission of the plan of correction does not indicate ar admission by Aspen Place He Campus that the findings and allegations contained herein a accurate and true representati of the care and services provide to the residents of Aspen Place Health Campus. This facility recognized its obligation to prolegally and medically necessal care and services to its resider in an economic and efficient manner. The facility herein maintains it is in substantial compliance with the requirement of participation for comprehense health care facilities. (for Title 18/19 programs). Attached you will find our Plan of Correction Aspen Place Health Campus four annual survey conducted of May 13th, 2025. We initiated immediate interventions when concerns were identified on the date. We respectfully request desk review for this plan of correction. If you need any information or paperwork, plead on not hesitate to contact us a (812) 527-2222. Sincerely, Mikayla Schneider, Executive Director	n alth re ons ded e ovide ry nts ents sive ou for on is	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Mikayla Schneider Executive Director 05/29/2025

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: A1OT11 Facility ID: 012854 If continuation sheet Page 1 of 24

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told her it wasn't enough and threw the wipes down on the ground. She went and got the suggestive of 100% compliance may result in cessation as to the							ule		
down on the ground. She went and got the may result in cessation as to the			•			.	20		
I resident a pack of wipes and went back into the I IIIOIIIIUIIIII plan.		_	——————————————————————————————————————			<u> </u>	ı ı c		
bathroom. The resident was sitting on the toilet		_	-			monitoring plan.			
with the wheelchair in front of her. She went to									
give the resident the wipes and they hit the back									
of the wheelchair and landed in the seat. She									
never threw the wipes at her. She asked the									

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155797	ľ	JILDING	nstruction 00	(X3) DATE COMPL 05/13 /	ETED
	PROVIDER OR SUPPLIER PLACE HEALTH CA		STREET ADDRESS, CITY, STATE, ZIP COD 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	resident if she need her no. The nurse we into the resident's rewanted to make a country but her toom and the reside talk with the CNA is and made sure anoth that resident since to that resident since to During an interview Director of Nursing gotten called to the related to an accusa a package of wet we prior. The CNA wa gone and talked with taking care of that resolve the issue, but to her about it. She believe the CNA to the resolve the issue, but to her about it. She believe the CNA that The facility investigned but was not a type of the call but was not a type of the call tight, and the resolve the statement of the call light, and the resolve had asked her is the had asked her is the call sight, and the resolve had asked her is the had asked her is the call sight, and the resolve had asked her is the call sight, and the resolve had asked her is the call sight, and the resolve had asked her is the call sight, and the resolve had asked her is the call sight, and the resolve had asked her is the call sight, and the resolve had asked her is the call sight.	ed anything else and she told forking that night had her go form because the resident complaint and the nurse wanted from. They all went into the ent said she wasn't going to in the room. She left the room ther staff member has cared for that night. If you had business office on a Friday tion that CNA 11 had thrown tipes at the resident a few days is working that day and had her. She was removed from the end of the her. She was removed from the end of the her. She was removed from the end of the her. She was removed from the end of the her. She was removed from the end of the her. She was removed from the end of the her. She was removed from the end of the her. She was removed from the end of the her sident wouldn't speak investigated and did not rew the wipes at the resident. If the resident wouldn't speak investigated and did not rew the wipes at the resident. If the resident wouldn't speak investigated and did not rew the wipes at the resident. If the resident wouldn't speak investigated and did not rew the wipes at the resident. If the resident wouldn't speak investigated and did not rew the wipes at the resident. If the resident wouldn't speak investigated and did not rew the wipes at the resident.		TAU TAU			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155797	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY TPLETED 13/2025
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP (
ASPEN F	PLACE HEALTH CA	MPUS		NSBURG, IN 47240	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ; CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	needed to file a conshe would need to get the room to get one station to get the form the resident because CNA explained that wipes but she was buntil she could get I LPN 12 has asked ther to get both sides entered the room, the brought the CNA with she wouldn't talk to to someone later. - A written statement 04/30/25 Resident 20 to tell her about an Resident 20 had tolwipes at her. - A written statement 04/29/25 she was as roommate when Reasking for wet wipes few wipes, but the rown wanted a new pack, her some when she gotten a pack of wipresident's wheelchat to go into the resident's	replaint. The LPN explained that get a complaint form and left. She walked to the nurse's rm and asked CNA 11 about the tresident was upset. The at the resident had wanted busy so she gave her a handful ner a pack, but she was upset. CNA 11 to go to the room with so of the story. When they he resident asked why she had with her. The resident had said the LPN, and she would talk the LPN, and she would talk the treatment of the treatment of the sisting Resident 20's sident 20 was in the bathroom and the resident and the she would get was done. She had gone and the said put them in the sir. The nurse had wanted her ent's room and the resident that she would just talk to the ad tried to keep herself away	TAG	DEFICIENCY		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIER		2320 N	ADDRESS, CITY, STATE, ZIP COD I MONTGOMERY ROAD NSBURG, IN 47240	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION FREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	During an interview DON indicated staf abuse immediately. She would immedia situation and report should have reported. The clinical record on 05/08/25 at 10:1 Data Set (MDS) assindicated the resident's diagnoses limited to, anemia, indicated, malnutrition. During an interview Administrator indices.	to her or the Administrator. Itely remove the staff from the it to the state. The staff d this incident sooner. for Resident 20 was reviewed 5 A.M. A Quarterly Minimum lessment, dated 02/13/25, in twas cognitively intact. The included, but were not heart failure, hypertension, on, depression, and bipolar. 7, on 05/13/25 at 2:45 P.M., the ated they did not have a policy new would follow the state.	TAG	DETALENCTI	DATE
SS=D Bldg. 00	Quality of Care	ions and intermions the facility	F 0.004	Decident 20 had no advance	05/21/2025
Bldg. 00	failed to follow a pl blood pressure mon reviewed for quality	riew and interview, the facility hysician's order related to itoring for 1 of 15 residents of care. (Resident 26)	F 0684	Resident 26 had no adverse effects from said deficient practice. No other residents waffected. All residents with daily BPs we	ere
	on 05/08/25 at 10:3 Data Set (MDS) ass indicated the reside impaired. The resid were not limited to, hypoxia, hypertensi	for Resident 26 was reviewed 5 A.M. A Quarterly Minimum dessment, dated 04/18/25, and was severely cognitively ent's diagnoses included, but acute respiratory failure with on, non-Alzheimer dementia, y, depression, and psychotic		audited and for missing values Clinical staff educated on the Standard practice of following orders, specifically on daily blo pressures. 2 random Residents with daily blood pressure orders will be audited by the DHS/ADHS/Designee for	ood

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
		155797	B. W	ING		05/13/	2025
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	disorder. A physician's order, 02/24/25, indicated resident's blood pre. The resident's clinic blood pressures for - 02/02/25 through (-02/08/25, -02/09/25, -02/11/25 through (-02/17/25, -02/19/25, -02/20/25, -02/22/25, and -02/23/25. During an interview 15 indicated if a phyvital signs to be modocumented the in I Administration Recomporate Clinical Standard on thave a policial and the control of the comporate Clinical Standard on the component of the compon	y, on 05/12/25 at 9:18 A.M., RN ysician ordered for a resident's mitored then they would be Electronic Medication		TAG	completion and parameter ord followed 3 times a week for 4 weeks, 1 time a week for 4 weeks, monthly for 3 months. The results of these audits will reviewed by the QAPI commit overseen by the ED. Findings be reviewed during the campumonthly QAPI meeting in to determine the frequency as to monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	beks, be tee will is the	DATE
F 0690	483.25(e)(1)-(3)						
SS=D Bldg. 00	Based on interview failed to ensure resi infection received a manner for 2 of 15	and record review, the facility dents with a urinary tract antibiotic treatment in a timely residents reviewed for (Resident 26 and 31)	F 06	690	Residents 31 and 26 have sind been cleared of a UTI and sho symptoms. No other residents were affected by said deficient	w no	05/31/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155797	B. W	ING		05/13/	/2025
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
AODENI		MPLIC			MONTGOMERY ROAD		
ASPEN I	PLACE HEALTH CA	AMPUS		GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID BROWINED'S BLANGE CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					All residents with pending urin	е	
	Findings include:				cultures have been audited wi	th no	
					culture results received as of y	et.	
	1. The clinical reco	rd for Resident 26 was reviewed			Once they are received , the N	1D	
	on 05/08/25 at 10:3	5 A.M. A Quarterly Minimum			will be immediately notified for		
	Data Set (MDS) ass	sessment, dated 04/18/25,			treatment if needed and thus		
	indicated the reside	nt was severely cognitively			documented. Staff in serviced		
	impaired. The resid	ent's diagnoses included, but			regarding the standard of Prac	tice	
	were not limited to,	acute respiratory failure with			in notifying the MD immediate	ly	
	hypoxia, hypertensi	on, non-Alzheimer dementia,			once results are received and		
	malnutrition, anxiet	ty, depression, and psychotic			treating positive cultures with t	he	
disorder.				MD orders in acceptable			
				timeliness.			
	A Progress Note, da	ated 04/15/25 at 1:51 P.M.,					
	indicated the reside	nt's urine was obtained for a			2 Residents(if present)with		
	Urinalysis Culture a	and Sensitivity (UA C&S).			positive urine cultures will be		
					audited by the IP/DHS/designe	ee	
	_	ated 04/17/25 at 2:47 P.M.,			for timeliness of treatment 3 tir	nes	
	indicated the reside	nt's urine culture was pending			a week for 4 weeks, 1 time a v	veek	
	at that time.				for 4 weeks, every other week	for 4	
					weeks, monthly for 3 months.		
		ated 04/21/25 at 3:07 P.M.,					
		nt's urine culture result					
		Fract Infection (UTI) and a new			The results of these audits will		
		for Macrobid (an antibiotic)			reviewed by the QAPI commit		
	100 milligrams, twi	ce a day for 10 days.			overseen by the ED. Findings		
					be reviewed during the campu	S	
		rt document indicated the			monthly QAPI meeting in to		
		collected on 04/14/25 at 2:15			determine the frequency as to	the	
		e laboratory (lab) on 04/16/25			monitoring plan. Findings		
	·	the culture results were			suggestive of 100% compliand		
	reported on 04/18/2	5 at 10:54 P.M.			may result in cessation as to the	ne	
	2 771 1: : 1	16 D :1 :21			monitoring plan.		
		rd for Resident 31 was reviewed					
		P.M. An Annual MDS					
assessment, dated 02/04/25, indicated the resident							
	was cognitively intact. The resident's diagnoses						
	included, but were not limited to, metabolic						
	encephalopathy, and						
	hypertension, neuro	ogenic bladder, diabetes,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIEF		2320 N	ADDRESS, CITY, STATE, ZIP COD 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	respiratory failure.	ition, anxiety, depression, and			
	indicated the reside	ated 03/11/25 at 4:52 P.M., nt's urine was obtained and tor waiting for the lab to pick it			
	A.M., indicated the catheter replaced or	resident had their urinary a 03/11/25 due to leaking and a nd was pending at time of visit.			
	indicated the Nurse and a new order wa	nted 03/17/25 at 11:55 P.M., Practitioner was in for rounds s received to start the resident illigrams, twice a day for 10			
	urine was collected received at the lab	on 03/11/25 at 4:15 P.M., on 03/12/25 at 1:51 P.M., and were reported on 03/14/25 at			
	03/27/25, indicated	the resident was to receive rams, twice a day, for 10 days.			
	Administration Rec	ectronic Medication ord indicated the resident had at dose of the antibiotic until P.M. to 10:00 P.M. due to the navailable.			
	15 indicated when t C&S, they would of ready for the lab to	hey received orders for a UA btain the urine and have it pick it up. The lab techs came I have the preliminary results			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIEF		2320 N	ADDRESS, CITY, STATE, ZIP COD I MONTGOMERY ROAD NSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFILIENCY)	(X5) COMPLETION DATE
	by the afternoon. If cultured, it would to results back. Once to would send them to should start on an a when the results we physician available results of the culture. During an interview the Infection Prever resident had an ordes staff would get the up in the evening. To came back within 2 came back after 72 seeing the culturer as should be calling the Residents should start 72-84 hours after old came to the facility and staff could always There were some must be labs online. During an interview Corporate Clinical Start of the st	the urine needed to be ake 48 to 72 hours to get those they had the results they the physician. The resident nitibiotic as soon as possible are back. There was always a to call once they got the e back to get orders. 7, on 05/13/25 at 10:08 A.M., nitionist indicated when a ter for a UA C&S, the nursing urine, and the lab would pick it the preliminary results usually 4 hours, and the final culture hours. If the staff were not esults after 72 hours, then they the lab to obtain those results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab and get results. The lab every day except Saturdays and the lab every da			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration	n Status Maintenance			
	failed to monitor da ordered medication monitor meal consu	view and interview, the facility aily weights, administer an related to fluid retention, and amptions for 2 of 3 residents on. (Resident 27 and 26)	F 0692	Resident 26 was assessed, a no adverse effects resulted in deficient practice. All residents with daily weight orders and PRN Lasix orders	said

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If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155797	B. W	ING		05/13/	2025
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEI	₹			MONTGOMERY ROAD		
ASPEN I	PLACE HEALTH CA	AMPUS			NSBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	Findings include:				audited. Meal consumptions v		
					audited for absence in our car	re	
		rd for Resident 27 was reviewed			assist program. Staff were		
		A.M. A Quarterly Minimum			educated on documentation of	of	
		sessment, dated 02/27/25,			meal consumptions. Licensed		
		ent was cognitively intact. The			staff were educated on follow	-	
	_	s included, but were not			physicians orders, concentrat	ion	
	limited, heart disea	se, hypertension, and diabetes.			on obtaining daily weights as		
					ordered and administering PF	RN	
		vsician's order, with a start			Lasix as ordered.		
date of 10/28/24, indicated the resident was to be							
	weighed daily.				2 random audits of residents	with	
					daily weights charted will be		
		vsician's order, with a start			conducted by		
		adicated a PRN (as needed)			DHS/ADHS/designee 3 times		
		o be administered if the		week for 4 weeks, 1 time a week			
		pounds in one day or five		for 4 weeks, every other week for 4			
	pounds in a week.				weeks, monthly for 3 months.		
					2 random audits of residents	with	
		cal record lacked a document			daily weights and parameter		
	weight for the follo	wing dates:			orders will be conducted by		
					DHS/ADHS/designee 3 times		
	- 03/05/25,				week for 4 weeks, 1 time a we		
	- 03/07/25,				for 4 weeks, every other week		
	- 03/08/25,				weeks, monthly for 3 months.		
	- 03/13/25,				2 random residents' meal		
	- 03/28/25,				consumption documentation v		
	- 03/30/25,				be audited DHS/ADHS/desigr		
	- 03/31/25,				by 3 times a week for 4 weeks		
	- 04/01/25,				time a week for 4 weeks, ever	-	
	- 04/02/25.				other week for 4 weeks, mont	hly	
	- 04/03/25,				for 3 months.		
	- 04/06/25,						
	- 04/10/25,				The results of these audits wi		
	- 04/16/25,				reviewed by the QAPI commit		
	- 04/24/25,				overseen by the ED. Findings		
	- 04/29/25, and				be reviewed during the campus		
	- 05/01/25.				monthly QAPI meeting in to		
					determine the frequency as to	the	
	The Resident's weight gain was two pounds or				monitoring plan. Findings		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIEF PLACE HEALTH CA		2320 1	ADDRESS, CITY, STATE, ZIP COD N MONTGOMERY ROAD NSBURG, IN 47240	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
TAG		wing days and a PRN dose of nistered:	TAG	suggestive of 100% complia may result in cessation as to monitoring plan.	
	- 05/05/25 weight weight weight an interview Qualified Medication with the rising or between 6 mechanical lift had weight, so even if the up their weight counotify the nurse of the would give permiss	vas 221 pounds, vas 203 pounds, vas 205 pounds, vas 205 pounds, vas 208.3 pounds, vas 206.6 pounds, vas 209.1 pounds, vas 205.2 pounds, and			
	15 indicated the CN weight first thing of She would look at t	on 05/13/25 at 1:06 P.M., RN IA would obtain the resident's f a morning and report it to her. he previous day's weight and feation if there was a weight to pounds.			
	Corporate Clinical did not have a polic orders, it was just so clinical record for F 05/08/25 at 10:35 A	y on 05/13/25 at 3:27 P.M., Support Nurse indicated they y for following physician randards of practice.2. The Resident 26 was reviewed on L.M. A Quarterly Minimum Data and 04/18/25, indicated the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/13/2025
	PROVIDER OR SUPPLIER PLACE HEALTH CAMPUS	2320 N	ADDRESS, CITY, STATE, ZIP COD MONTGOMERY ROAD NSBURG, 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DBE COMPLETION
	resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, hypertension, non-Alzheimer dementia, malnutrition, anxiety, depression, and psychotic disorder. The resident's clinical record lacked documented meals for the following dates and times for a resident with a diagnosis of malnutrition: - 03/01/25 at dinner, - 03/02/25 at breakfast, lunch, and dinner, - 03/03/25 at breakfast and lunch, - 03/12/25 at dinner, - 03/15/25 at breakfast and lunch, - 03/17/25 at breakfast and lunch, - 03/17/25 at breakfast and lunch, - 03/30/25 at breakfast and lunch, - 04/17/25 at breakfast and lunch, - 04/18/25 at breakfast and lunch, - 04/18/25 at breakfast and lunch, - 04/18/25 at breakfast and lunch, - 05/10/25 at breakfast and lunch, - 05/10/25 at breakfast and lunch, - 05/10/25 at breakfast and lunch, - 05/11/25 at dinner. During an interview, on 05/13/25 at 11:12 A.M., Certified Nurse Aide 14 indicated resident meals were documented in the resident's clinical record. The current facility policy titled; "Guidelines for Meal Service" was provided by the Director of Nursing on 05/13/25 at 1:23 P.M. The policy indicated, "Meal intake should be recorded in the electronic health record"			
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155797	B. WI			05/13/	
							-
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
AODENIE		MDUO			MONTGOMERY ROAD		
ASPEN F	PLACE HEALTH CA	MPUS		GREEN	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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
Bldg. 00	Srvcs/Procedures/	/Pharmacist/Records					
	Based on record rev	riew and interview, the facility	F 07	755	Resident 26 has had no adver	se	05/31/2025
	failed to ensure med	lications were available for 1 of			effects from said deficient		
	15 residents reviewe	ed for pharmacy services.			practice. No other residents w	ere	
	(Resident 26)				affected.		
	Findings include:				All residents with regularly ord	ered	
					narcotic pain medications were		
	The clinical record	for Resident 26 was reviewed			audited for proper administrati	on	
	on 05/08/25 at 10:33	5 A.M. A Quarterly Minimum			as ordered. Licensed clinical	staff	
	Data Set (MDS) ass	essment, dated 04/18/25,			were in serviced regarding wh	at to	
	indicated the resider	nt was severely cognitively			do when an ordered medication	n is	
	impaired. The reside	ent's diagnoses included, but			not present in the med cart.		
	were not limited to,	acute respiratory failure with					
	hypoxia, hypertensi	on, non-Alzheimer dementia,			2 residents with regularly orde	red	
	malnutrition, anxiet	y, depression, and psychotic			narcotic pain medication will b	е	
	disorder.				audited for proper administrati	on	
					by DHS/ADHS/designee as		
	A physician's order,	dated 11/24/24 through			ordered and available 3 times	а	
	·	the resident was to receive			week for 4 weeks, 1 time a we	ek	
	tramadol (a pain me	edication) 50 milligrams, twice a			for 4 weeks, every other week	for 4	
	day from 6:00 A.M.	to 10:00 A.M. and 6:00 P.M. to			weeks, monthly for 3 months.		
	10:00 P.M.						
					The results of these audits will	be	
		lectronic Medication			reviewed by the QAPI commit	tee	
		ord indicated the resident had			overseen by the ED. Findings		
	not received the me	dication on the following			be reviewed during the campu	S	
	dates and times:				monthly QAPI meeting in to		
					determine the frequency as to	the	
		6:00 P.M. to 10:00 P.M., the			monitoring plan. Findings		
		n was not administered due to			suggestive of 100% compliand		
	the medication bein	g unavailable.			may result in cessation as to the	he	
					monitoring plan.		
		6:00 A.M. to 10:00 A.M., the					
		n was not administered due to					
		g unavailable and the resident					
	needed a new prescr	ription.					
		6:00 A.M. to 10:00 A.M., the					
	resident's medicatio	n was not administered due to	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155797	B. W	ING		05/13/	2025
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD		
					MONTGOMERY ROAD		
ASPENI	PLACE HEALTH CA	AMPUS		GREEN	ISBURG, IN 47240		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	the medication bein	R LSC IDENTIFYING INFORMATION		TAG	DLI ICILICI I		DATE
	the medication bein	ig unavanaoic.					
	- On 01/26/25 from	6:00 A.M. to 10:00 A.M., the					
	resident's medication was not administered due to						
	the medication being	ig unavailable.					
	On 01/28/25 from	6:00 P.M. to 10:00 P.M., the					
		on was not administered due to					
	the medication being						
		6:00 A.M. to 10:00 A.M., the					
		on was not administered due to					
	the medication bein	ig unavailable.					
	A Physician Progre	ss Note, dated 01/21/25,					
		nt was seen by the Nurse					
		indication a new prescription					
		tramadol. The resident was					
	being seen for havin	ng recurring abdominal					
	discomfort and a ga	allbladder ultrasound order.					
	A Progress Note de	ated 01/25/25 at 7:45 P.M.,					
	_	nt was out of Tramadol and					
		ription. The writer went to the					
	_	the provider for a 3-day					
	supply. The request	t was placed in the provider					
	book at the 200 Hal						
	A Physician Drawn	ss Note, dated 01/27/25 at 6:11					
		resident was seen by the					
		The note lacked any indication					
		eded a new prescription for					
	tramadol.	1 1					
		101/00/05 . 0 10 1 35					
	-	ated 01/29/25 at 8:10 A.M.,					
		e was sent to the Nurse					
	Fractitioner request	ing a hard script for tramadol.					
	During an interview	v, on 05/12/25 at 9:18 A.M., RN					
		a resident was out of a					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155797	A. BUILDING B. WING	00	COMPLETED 05/13/2025		
		133797	_		03/13/2023		
NAME OF P	ROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD N MONTGOMERY ROAD			
ASPEN F	PLACE HEALTH CA	AMPUS	GREENSBURG, IN 47240				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION uired a prescription they could	TAG	DEFICIENCE	DATE		
	_	dose from the emergency					
		ld need to call the physician to					
		ent to the pharmacy. They					
	should have a new prescription within 24 hours. If						
	_	unicated with the physician					
		ons being unavailable, it should					
	be documented in a	progress note.					
	The current facility	policy titled, "Guidelines for					
	-	', with a review date of					
	12/17/24 was provi	ded by the Director of Nursing					
		P.M. The policy indicated,					
		he policy it to establish					
	of medication order	in the receiving and recording					
	of medication order	·S					
	The current facility	policy titled, "Medication					
	Ordering and Recei	ving from Pharmacy", with a					
		8, was provided by the					
	_	g on 05/12/25 at 3:01 P.M. The					
		.Reorder medication several					
	•	need, as directed by the I delivery schedule, to assure					
	an adequate supply						
	3.1-25(a)						
F 0760	483.45(f)(2)						
SS=D	Residents are Fre	e of Significant Med Errors					
Bldg. 00							
		on, interview, and record	F 0760	Resident 23 was assessed fo			
	-	failed to ensure medications appropriately to prevent		adverse effects from said defi practice. Her lab value was w			
		ion errors for 1 of 3 residents		normal limits. Her potassium			
	_	icant medication errors.		changed to <u>a liquid form</u> . All			
	(Resident 23)			residents with medications that	at		
				should not be crushed can be	at		
	Findings include:			risk potentially.			
l l			1		I		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155797	B. W	ING	<u> </u>	05/13	/2025
				_			
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					MONTGOMERY ROAD		
ASPEN F	PLACE HEALTH CA	AMPUS		GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	OMA 9 was observ	ed preparing medications for			All residents that take crushed		
	1	12/25 at 8:48 A.M. QMA 9			medications were audited for		
		and opened the plastic			medicines ordered that should	l not	
		ined the resident's various			be crushed . Licensed staff,	11100	
		aced the medications in a cup.			including QMA 9 were in servi	ced	
	_	cluded, but were not limited to,			on the "Medications not to be	ocu	
		t (mEq) Extended Release (ER)			crushed list".		
	_	tablet. QMA 9 indicated the			Grasiica list .		
		edications crushed. She			2 random residents that requir		
		vitamin supplement tablet from			crushed medications will be	C	
		and indicated the gel tablet			audited by DHS/ADHS/design	00	
	•	. She poured the remaining			for medications that should no		
		clear packet and crushed them			crushed 3 times a week for 4	it be	
		-			-	حادم	
	_	r on the medication cart. She			weeks, 1 time a week for 4 we		
	1 -	medications back into the			every other week for 4 weeks,		
		and the gel tablet to the cup,			monthly for 3 months.		
	-	minister the medications to the					
	resident.				The results of these audits wi		
	D	05/12/25 + 0.00 + 3.5			reviewed by the QAPI commit		
		v, on 05/12/25 at 9:09 A.M.,			overseen by the ED. Findings		
		nere were several medications			be reviewed during the campu	IS	
		ed to be crushed because of			monthly QAPI meeting in to		
		nedications. There was a "do			determine the frequency as to	tne	
		e medication cart. She			monitoring plan. Findings		
		d indicated the potassium			suggestive of 100% compliand		1
		dministered to the resident			may result in cessation as to t	he	
		rush list. She was not aware			monitoring plan.		
		crushed. She learned					
	something new.						
		cal record was reviewed on					
		M. A Quarterly Minimum Data					
		ed 03/11/25, indicated the					
		ly cognitively impaired. The					
	1	s included, but were not					
	1	artery disease, hypertension,					
	and malnutrition.						
	The resident's most	recent laboratory values were					

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reviewed, and her potassium level was within

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 05/13/2025		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The "Medications In revision date of 12/ Corporate Clinical 3:30 P.M. The list in	Not To Be Crushed" list, with a 22, was provided by the Support Nurse on 05/13/25 at ndicated the Potassium not to be crushed because it lease medication.				
F 0761 SS=D Bldg. 00	failed to appropriat		F 07	761	Resident 30 had no adverse effects from said deficient practice. The insulin pen and fish oil were discarded and ne were available to give.	
	On 05/13/25 at 1:13 Cart was observed following: - A Basaglar insulin was 1/2 full and was on" date, and - A 198-milliliter b. Resident 30. The be	3 P.M., the 100 Hall Medication with RN 10 and contained the a pen for Resident 30. The pen is not labeled with an "opened of liquid fish oil for ottle was two-thirds full and han opened-on date.			All residents with medications stored in the med cart have the potential to be affected. All medication carts were audited opened insulin or liquids with open dates. Licensed staff we educated regarding writing open dates on all liquid medications insulins. 2 Random med cart audits with conducted by DHS/ADHS/Designee to ensure the potential to	d for out ere pen s and
	10 indicated the resinsulin twice a day	v, on 05/13/25 at 1:18 P.M., RN ident received 32 units of the and received 2.5 ml of the fish ications should have been d on dates.			the absence of opened liquid medications or insulin pens without open dates 3 times a week for 4 weeks, 1 time a we for 4 weeks, every other week	eek

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The Basaglar insulin pen package insert indicated,

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weeks, monthly for 3 months.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155797	B. WI	NG		05/13/	2025
				CED FIRE	ADDRESS STEW STATE THE SOR		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
AODENIE	N AOE HEALTH OA	MDUO			MONTGOMERY ROAD		
ASPEN F	PLACE HEALTH CA	IMPUS		GREEN	ISBURG, 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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	"Throw away all i	nsulinin use after 28 days,			The results of these audits will	be	
	even if there is insu	lin left"			reviewed by the QAPI committ	tee	
					overseen by the ED. Findings	will	
	The current facility	policy, titled "MEDICATION			be reviewed during the campu	s	
	STORAGE IN THE	FACILITY", with a revision			monthly QAPI meeting in to		
	date of 11/18, was p	provided by the Corporate			determine the frequency as to	the	
	Clinical Support Nu	rse on 05/13/25 at 3:15 P.M.			monitoring plan. Findings		
	The policy indicated	d, "When the original seal of			suggestive of 100% complianc	e	
	a manufacturer's con	ntainer or vial is initially			may result in cessation as to the	ne	
	broken, the contained	er or vial will be dateda "date			monitoring plan.		
	opened" sticker shall	ll be placed on the					
	medication"						
	2 1 25(a)						
	3.1-25(o)						
F 0880	483.80(a)(1)(2)(4)	(e)(f)					
SS=E	Infection Prevention	on & Control					
Bldg. 00							
	Based on record rev		F 08	380	The facility established an effe	ctive	05/31/2025
		ility failed to follow infection			infection control tracking and		
	-	elated to infection tracking and			trending system per guidelines		
	-	iced Barrier Precautions (EBP)			Resident 10 and resident 40 h	ad	
	related to infection	control. (Residents 10 and 40)			no adverse effects from said		
					deficient practice EBP related.		
	Findings include:						
					All residents requiring EBP and		
	_	of the Infection Control			antibiotic trending and tracking		
	_	ing documentation on			have the potential to be affected		
		M., The facility lacked			Staff were educated on EBP a	and	
		g of antibiotic use for			how and when to apply these		
	February and March	1 2025.			precautions (including RN 7 ar RN 8).	nd	
	During an interview	on 05/13/25 at 3:35 P.M., the					
	_	nist indicated she came to this			The tracking and trending syst	em	
	facility in April and	infections and antibiotic			will be audited by the		
		ed in February and March.			DHS/ADHS/Designee for		
		-			completion with antibiotics ord	ered	
	The current facility	policy titled, "Infection			3 times a week for 4 weeks, 1		
		trol Program" with a review			time a week for 4 weeks, ever	y	
	date of 12/17/24, wa	_			other week for 4 weeks, month		

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

PRINTED: 06/10/2025 FORM APPROVED OMB NO. 0938-039

	of correction identification number 155797	A. BUILDING <u>0</u> B. WING	00	COMPLETED 05/13/2025
	PROVIDER OR SUPPLIER PLACE HEALTH CAMPUS	2320 N MO	RESS, CITY, STATE, ZIP COD ONTGOMERY ROAD URG, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Administrator on 05/06/25. The policy indicated"The purpose of this policy is to: To 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 infectionsThe campus has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseasesThe campus shall designate a member of the clinical team to monitor the campusprogram to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting"2. The clinical record for Resident 10 was reviewed on 05/08/25 at 1:33 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/09/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), hypertension, heart failure, dementia. The resident had an unhealed pressure ulcer on her right buttocks. An open-ended physician's order, with a start date of 12/13/24, indicated staff were to use Enhanced Barrier Precautions (EBP), wearing a gown and gloves at minimum during high contact care activities. During an observation, on 05/12/25 2:09 P.M., the resident's door had a sign on it that indicated staff were to "STOP" and that the resident was in "ENHANCED BARRIER PRECAUTIONS". Everyone must wear gloves and a gown for High-Contact Resident Care Activities, including wound care. RN 7 entered the resident's room and provided direct care as she removed and then reattached the wound dressing to visualize the wound without donning a gown.	Ra tha by tim a v we mo Th rev ove be mo de mo sug	r 3 months. andom care audits for resider at require EBP will be conduct the DHS/ADHS/Designee 3 mes a week for 4 weeks, 1 tin week for 4 weeks, every other eek for 4 weeks, monthly for sonths. The results of these audits will eviewed by the QAPI committed erseen by the ED. Findings are reviewed during the campus conthly QAPI meeting in to extermine the frequency as to conitoring plan. Findings are gresult in cessation as to the onitoring plan.	ted ne er 3 be ee will s the

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

PRINTED: 06/10/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155797	 JILDING	00	COMPL 05/13/	ETED
	PROVIDER OR SUPPLIER		2320 N	DDRESS, CITY, STATE, ZIP COD MONTGOMERY ROAD SBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	7 indicated nursing gown when providing who are in EBP. She when she was touch Resident 10. 3. Respective and the resident impaired. The resident were not limited to, dementia, and peripheresident had pressure that were present or the resident's curre but were not limited a start date of 04/29 was in EBP and start gloves at minimum activities. During an observation the resident's door he staff were to "STOF" "ENHANCED BAFE Everyone must weat High-Contact Resident wound care. RN 7 aroom and proceeded wound care treatmed wounds without dor During an interview 7 indicated nursing gown when providing who are in EBP. She	nt physician's orders included, d to, an open-ended order, with 1/25, that indicated the resident ff were to wear a gown and during high-contact care son, on 05/12/25 at 1:21 P.M., and a sign on it that indicated or and that the resident was in RRIER PRECAUTIONS". It gloves and a gown for lent Care Activities, including and RN 8 entered the resident's d to cleanse and administer nts to the resident's multiple				

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	lì í	ULTIPLE CO JILDING	ONSTRUCTION 00	(X3) DATE COMPL	
ANDILAN	or connection	155797	B. W			05/13/	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
F 0947 SS=E Bldg. 00	Barrier Precautions Procedure", dated 0 DON on 05/12/25 a indicated, "EBP w high-contact care ac following condition wounds, including to ulcersat minimum gowns during high- 3.1-18(b) 483.95(g)(1)-(4) Required In-Service Based on record rev failed to ensure the hours of dementia to hire and three hours records reviewed. (c) Findings include: The employee record Employee Experient The following staff skilled unit failed to hours of dementia to residents that had a - Certified Nurse At 06/19/24 and had 1 - CNA 3 was hired dementia training, a	on 10/16/24 and had 1.5 hours	F 09	947	CNA 2 CNA 3 and CNA 5 Employees that have not had initial 6 hours of dementia trai or 3 hours of annual dementia training will be taken off scheountil they achieve their needed training. Staff educated on the requirements and need for thi training. Staff that has not had training is taken off schedule achieved. 3 Random audits of the annual and initial dementia training waudited by the BOM/ED/desig 3 times a week for 4 weeks, 1 time a week for 4 weeks, ever other week for 4 weeks, mont for 3 months.	ning dule d s d this until ill be nee	05/31/2025

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797 A. BUILDING 00 B. WING			COMPLETED 05/13/2025		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD MONTGOMERY ROAD	
ASPEN F	PLACE HEALTH CA	MPUS		NSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	the Employee Experiment had provided all the training in the employer to the staff through or responsibility to condepartment manager which staff member. The department manatheir staff. She belie to have six hours of unsure of older employers an interview. Corporate Clinical Stacility did not have	rience Manager indicated she documented dementia byee files. Reports were sent email, and it was their implete the training. The received a report indicating is still had training to complete. Inagers were to follow up with eved new staff members were dementia training and was loyees. To on 05/09/25 at 11:28 A.M., Support Nurse indicated the a policy related to dementia follow State and Federal		reviewed by the QAPI committ overseen by the ED. Findings be reviewed during the campu monthly QAPI meeting in to determine the frequency as to monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	will s the
R 0000					
Bldg. 00	Survey. This visit in State Licensure Survey Survey dates: May 6 Facility number: 012 Residential Census: These State Residential accordance with 416	5, 7, 8, 9, 12, and 13, 2025. 2854 27 Itial Findings are cited in	R 0000	This submission of the plan of correction does not indicate ar admission by Aspen Place He. Campus that the findings and allegations contained herein a accurate and true representati of the care and services proviot to the residents of Aspen Place Health Campus. This facility recognized its obligation to prolegally and medically necessal care and services to its resider in an economic and efficient manner. The facility herein maintains it is in substantial compliance with the requirement	n alth re ons ded e ovide ry nts

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

PRINTED: 06/10/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155797		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 05/13/2025	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD N MONTGOMERY ROAD	
ASPEN F	PLACE HEALTH CA	MPUS	GREE	NSBURG, IN 47240	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
R 0087 Bldg. 00	410 IAC 16.2-5-1. Administration and Noncompliance Based on record reversal failed to ensure the hours of dementia to the hire and three hours records reviewed. (Complete Employee Experient The following staff assisted living demorequired number of a Certified Nurse A 06/19/24 and had 1.	d Management - view and interview, the facility staff had the required six raining within six months of annually for 3 of 10 employee CNA 2, CNA 3, and CNA 5) and were provided by the ce Manager on 05/08/25. members working on an enita unit failed to have the hours of dementia training: ide (CNA) 2 was hired on 5 hours of dementia training, on 12/20/24 and had 1 hour of	R 0087	of participation for compreher health care facilities. (for Title 18/19 programs). Attached yould find our Plan of Correction Aspen Place Health Campus our annual survey conducted May 13th, 2025. We initiated immediate interventions where concerns were identified on the date. We respectfully request desk review for this plan of correction. If you need any information or paperwork, pled on not hesitate to contact us at (812) 527-2222. Sincerely, Mikayla Schneider, Executive Director CNA 2 CNA 3 and CNA 5 Employees that have not had initial 6 hours of dementia train or 3 hours of annual dementia training will be taken off scheduntil they achieve their needed training. Staff educated on the requirements and need for this training. Staff that has not had training is taken off schedule achieved. 3 Random audits of the annual and initial dementia training was audited by the BOM/ED/desig 3 times a week for 4 weeks, even other week for 4 weeks, monto	nsive ou n for for on n nis ase at the ning a dule d s d this until al vill be gnee ry

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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		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/13/2025	
NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	- CNA 5 was hired of dementia training	on 10/16/24 and had 1.5 hours g.			for 3 months.		
	survey period and in the dementia unit on on the dementia unit on the dementia unit on the dementia unit on the dementia unit of the Employee Expensal provided all the training in the employee to the staff through responsibility to condepartment manage which staff members the department manage which staff. She beliet to have six hours of unsure of older employees the component of the department of the department management of the department	r, on 05/09/25 at 11:13 A.M., rience Manager indicated she documented dementia oyee files. Reports were sent email, and it was their emplete the training. The received a report indicating res still had training to complete. Inagers were to follow up with eved new staff members were dementia training and was			The results of these audits wil reviewed by the QAPI commit overseen by the ED. Findings be reviewed during the campu monthly QAPI meeting in to determine the frequency as to monitoring plan. Findings suggestive of 100% compliant may result in cessation as to t monitoring plan.	tee will is the	

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