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	05/13/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 6, 7, 8, 9, 12 and 13, 2025. Facility number: 012854 Provider number: 155797 AIM number: 201104690 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 reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 16, 2025.	F 0000	This submission of the plan of correction does not indicate an admission by Aspen Place Health Campus that the findings and allegations contained herein are accurate and true representations of the care and services provided to the residents of Aspen Place Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility herein maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs). Attached you will find our Plan of Correction for Aspen Place Health Campus for our annual survey conducted on May 13th, 2025. We initiated immediate interventions when concerns were identified on this date. We respectfully request desk review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 527-2222. Sincerely, Mikayla Schneider, Executive Director	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mikayla Schneider	Executive Director	05/29/2025

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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	Based on interview and record review, the facility failed to report an allegation of abuse in a timely manner for 1 of 15 residents reviewed for reporting of alleged violations. (Resident 20) Findings include: During an interview, on 05/06/25 at 1:16 P.M., Resident 20 indicated a few weeks ago she had gone to the bathroom and her wet wipes were gone. Certified Nurse Aide (CNA) 11 was assisting her roommate. The resident asked the CNA to get her some wipes because someone had taken hers out of the bathroom. The CNA gave her about five wipes and the resident told her that wouldn't be enough, and she wanted a full pack. The CNA had brought her a full pack of wipes and stood in the doorway to the bathroom and tossed the full package of wipes at her. The wipes hit the back of her wheelchair and landed in the seat. She believed the CNA was angry when she tossed the wipes into the bathroom. She reported to other staff member, but didn't think it had been taken care of. She felt safe in the building but thought it was unacceptable that the CNA tossed the wipes towards her. During an interview, on 05/12/25 at 1:26 P.M., CNA 11 indicated a few weeks ago she was assisting Resident 20's roommate when Resident 20 was in the bathroom asking for wet wipes. She handed the resident a few wipes, but the resident told her it wasn't enough and threw the wipes down on the ground. She went and got the resident a pack of wipes and went back into the bathroom. The resident was sitting on the toilet 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	F 0609	Resident 20 had no adverse effects due to said deficiency. An investigation was completed with no findings. No other residents were affected. CNA 11, QMA 13, and LPN 12 were immediately educated regarding the Abuse policy and procedure (concentrating on the reporting guidelines). Members of the IDT and staff were educated regarding the Abuse policy and procedure (concentrating on the reporting guidelines). The DHS/ED/Designee will perform random audits of staff to determine understanding of reportable guidelines/timeliness 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	05/31/2025

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	resident if she needed anything else and she told her no. The nurse working that night had her go into the resident's room because the resident wanted to make a complaint and the nurse wanted both of them in the room. They all went into the room and the resident said she wasn't going to talk with the CNA in the room. She left the room and made sure another staff member has cared for that resident since that night. During an interview, on 05/12/25 at 9:24 A.M., the Director of Nursing (DON) indicated she had gotten called to the business office on a Friday related to an accusation that CNA 11 had thrown a package of wet wipes at the resident a few days prior. The CNA was working that day and had gone and talked with her. She was removed from taking care of that resident. The resident made Qualified Medication Aide (13) aware that CNA 11 had thrown wipes at her the night that it happened. Licensed Practical Nurse (LPN) 12 had taken the CNA to the resident's room that night to resolve the issue, but the resident wouldn't speak to her about it. She investigated and did not believe the CNA threw the wipes at the resident. The facility investigation was provided by the DON on 05/13/25 at 11:23 A.M. The investigation included, but was not limited to the following: - A typed statement from Resident 20, dated 05/02/25 , that indicated the incident occurred on 04/28/25. The resident had indicated that CNA 11 had thrown a package of wipes at her. - A written statement from LPN 12, that indicated she had entered the resident's room to answer the call light, and the resident had appeared upset. She had asked her if she was ok and she said no that she was upset. The resident told her that she			

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	needed to file a complaint. The LPN explained that she would need to get a complaint form and left the room to get one. She walked to the nurse's station to get the form and asked CNA 11 about the resident because the resident was upset. The CNA explained that the resident had wanted wipes but she was busy so she gave her a handful until she could get her a pack, but she was upset. LPN 12 has asked CNA 11 to go to the room with her to get both sides of the story. When they entered the room, the resident asked why she had brought the CNA with her. The resident had said she wouldn't talk to the LPN, and she would talk to someone later. - A written statement from QMA 13 indicated on 04/30/25 Resident 20 had called her into the room to tell her about an incident with CNA 11. Resident 20 had told her that the CNA had thrown wipes at her. - A written statement from CNA 11 indicated on 04/29/25 she was assisting Resident 20's roommate when Resident 20 was in the bathroom asking for wet wipes. She handed the resident a few wipes, but the resident didn't like that and wanted a new pack. She told her she would get her some when she was done. She had gone and gotten a pack of wipes and put them in the resident's wheelchair. The nurse had wanted her to go into the resident's room and the resident didn't like that and that she would just talk to the "higher ups". She had tried to keep herself away from the resident's room. During an interview, on 05/12/25 at 2:13 P.M., CNA 14 indicated if a resident reported any type of abuse to her, she would report it to the Administrator immediately anytime of the day.			

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	During an interview, on 05/13/25 at 10:35 P.M., the DON indicated staff should report allegations of abuse immediately to her or the Administrator. She would immediately remove the staff from the situation and report it to the state. The staff should have reported this incident sooner. The clinical record for Resident 20 was reviewed on 05/08/25 at 10:15 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/13/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, diabetes, malnutrition, depression, and bipolar. During an interview, on 05/13/25 at 2:45 P.M., the Administrator indicated they did not have a policy for reporting, and they would follow the state guidelines. 3.1-28(b)(2)(c)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to follow a physician's order related to blood pressure monitoring for 1 of 15 residents reviewed for quality of care. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, indicated the 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	F 0684	Resident 26 had no adverse effects from said deficient practice. No other residents were affected. All residents with daily BPs were audited and for missing values . Clinical staff educated on the Standard practice of following orders, specifically on daily blood pressures. 2 random Residents with daily blood pressure orders will be audited by the DHS/ADHS/Designee for	05/31/2025

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	disorder. A physician's order, dated 01/30/25 through 02/24/25, indicated the staff were to check the resident's blood pressure daily. The resident's clinical record lacked document blood pressures for the following dates: - 02/02/25 through 02/04/25, - 02/08/25, - 02/09/25, - 02/11/25 through 02/13/25, - 02/17/25, - 02/19/25, - 02/20/25, - 02/22/25, and - 02/23/25. During an interview, on 05/12/25 at 9:18 A.M., RN 15 indicated if a physician ordered for a resident's vital signs to be monitored then they would be documented the in Electronic Medication Administration Record. During an interview, on 05/13/25 at 3:27 P.M., Corporate Clinical Support Nurse indicated they did not have a policy for following physician orders, it was just standards of practice. 3.1-37(a)		completion and parameter orders followed 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to ensure residents with a urinary tract infection received antibiotic treatment in a timely manner for 2 of 15 residents reviewed for laboratory services. (Resident 26 and 31)	F 0690	Residents 31 and 26 have since been cleared of a UTI and show no symptoms. No other residents were affected by said deficiency.	05/31/2025

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	Findings include: 1. The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, indicated the 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. A Progress Note, dated 04/15/25 at 1:51 P.M., indicated the resident's urine was obtained for a Urinalysis Culture and Sensitivity (UA C&S). A Progress Note, dated 04/17/25 at 2:47 P.M., indicated the resident's urine culture was pending at that time. A Progress Note, dated 04/21/25 at 3:07 P.M., indicated the resident's urine culture result showed a Urinary Tract Infection (UTI) and a new order was obtained for Macrobid (an antibiotic) 100 milligrams, twice a day for 10 days. A Laboratory Report document indicated the resident's urine was collected on 04/14/25 at 2:15 P.M., received at the laboratory (lab) on 04/16/25 at 12:10 P.M., and the culture results were reported on 04/18/25 at 10:54 P.M. 2. The clinical record for Resident 31 was reviewed on 05/07/25 at 2:56 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, anemia, heart failure, hypertension, neurogenic bladder, diabetes,		All residents with pending urine cultures have been audited with no culture results received as of yet. Once they are received , the MD will be immediately notified for treatment if needed and thus documented. Staff in serviced regarding the standard of Practice in notifying the MD immediately once results are received and treating positive cultures with the MD orders in acceptable timeliness. 2 Residents(if present)with positive urine cultures will be audited by the IP/DHS/designee for timeliness of treatment 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	

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	paraplegia, malnutrition, anxiety, depression, and respiratory failure. A Progress Note, dated 03/11/25 at 4:52 P.M., indicated the resident's urine was obtained and was in the refrigerator waiting for the lab to pick it up. A Physician Progress Note, dated 03/14/25 at 6:14 A.M., indicated the resident had their urinary catheter replaced on 03/11/25 due to leaking and a UA was obtained and was pending at time of visit. A Progress Note, dated 03/17/25 at 11:55 P.M., indicated the Nurse Practitioner was in for rounds and a new order was received to start the resident on Linezolid 600 milligrams, twice a day for 10 days, for a UTI. A Laboratory Report, indicated the resident's urine was collected on 03/11/25 at 4:15 P.M., received at the lab on 03/12/25 at 1:51 P.M., and the culture results were reported on 03/14/25 at 7:17 A.M. A physician's order, dated 03/17/25 through 03/27/25, indicated the resident was to receive linezolid 600 milligrams, twice a day, for 10 days. The March 2025 Electronic Medication Administration Record indicated the resident had not received the first dose of the antibiotic until 03/18/25 from 6:00 P.M. to 10:00 P.M. due to the medication being unavailable. During an interview, on 05/12/25 at 9:18 A.M., RN 15 indicated when they received orders for a UA C&S, they would obtain the urine and have it ready for the lab to pick it up. The lab techs came nightly. They would have the preliminary results			

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	by the afternoon. If the urine needed to be cultured, it would take 48 to 72 hours to get those results back. Once they had the results they would send them to the physician. The resident should start on an antibiotic as soon as possible when the results were back. There was always a physician available to call once they got the results of the culture back to get orders. During an interview, on 05/13/25 at 10:08 A.M., the Infection Preventionist indicated when a resident had an order for a UA C&S, the nursing staff would get the urine, and the lab would pick it up in the evening. The preliminary results usually came back within 24 hours, and the final culture came back after 72 hours. If the staff were not seeing the culture results after 72 hours, then they should be calling the lab to obtain those results. Residents should start on an antibiotic within 72-84 hours after obtaining the urine. The lab came to the facility every day except Saturdays and staff could always call the lab and get results. There were some nurses that had access to view the labs online. During an interview, on 05/12/25 at 3:15 P.M., Corporate Clinical Support Nurse indicated the facility did not have a policy on timeliness of labs. 3.1-49(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to monitor daily weights, administer an ordered medication related to fluid retention, and monitor meal consumptions for 2 of 3 residents reviewed for nutrition. (Resident 27 and 26)	F 0692	Resident 26 was assessed, and no adverse effects resulted in said deficient practice. All residents with daily weight orders and PRN Lasix orders were	05/31/2025

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	Findings include: 1. The clinical record for Resident 27 was reviewed on 05/09/25 at 9:16 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/27/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited, heart disease, hypertension, and diabetes. An open-ended physician's order, with a start date of 10/28/24, indicated the resident was to be weighed daily. An open-ended physician's order, with a start date of 10/28/24, indicated a PRN (as needed) dose of Lasix was to be administered if the resident gained two pounds in one day or five pounds in a week. The resident's clinical record lacked a document weight for the following dates: - 03/05/25, - 03/07/25, - 03/08/25, - 03/13/25, - 03/28/25, - 03/30/25, - 03/31/25, - 04/01/25, - 04/02/25. - 04/03/25, - 04/06/25, - 04/10/25, - 04/16/25, - 04/24/25, - 04/29/25, and - 05/01/25. The Resident's weight gain was two pounds or		audited. Meal consumptions were audited for absence in our care assist program. Staff were educated on documentation of meal consumptions. Licensed staff were educated on following physicians orders, concentration on obtaining daily weights as ordered and administering PRN Lasix as ordered. 2 random audits of residents with daily weights charted will be conducted by DHS/ADHS/designee 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. 2 random audits of residents with daily weights and parameter orders will be conducted by DHS/ADHS/designee 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. 2 random residents' meal consumption documentation will be audited DHS/ADHS/designee by 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings	

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	greater on the following days and a PRN dose of Lasix was not administered: - 03/19/25 weight was 218 pounds, - 03/20/25 weight was 221 pounds, - 04/11/25 weight was 203 pounds, - 04/12/25 weight was 205 pounds, - 04/19/25 weight was 205 pounds, - 04/20/25 weight was 208.3 pounds, - 04/26/25 weight was 206.6 pounds, - 04/27/25 weight was 209.1 pounds, - 05/04/25 weight was 205.2 pounds, and - 05/05/25 weight was 209 pounds. During an interview on 05/12/25 at 2:54 P.M., Qualified Medication Aide (QMA) 16 indicated she would obtain the resident's weight upon rising or between 6:00 A.M. and 10:00 A.M. The mechanical lift had a scale to obtain the resident's weight, so even if the resident didn't want to get up their weight could still be measured. She would notify the nurse of the weight, and the nurse would give permission for the PRN dose of Lasix to be given. Resident 26 was usually agreeable to being weighed. During an interview on 05/13/25 at 1:06 P.M., RN 15 indicated the CNA would obtain the resident's weight first thing of a morning and report it to her. She would look at the previous day's weight and administer the medication if there was a weight gain greater than two pounds. During an interview on 05/13/25 at 3:27 P.M., Corporate Clinical Support Nurse indicated they did not have a policy for following physician orders, it was just standards of practice.2. The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set assessment, dated 04/18/25, indicated the		suggestive of 100% compliance may result in cessation as to the monitoring plan.	

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	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, - 03/05/25 at breakfast and lunch, - 03/12/25 at dinner, - 03/15/25 at breakfast and lunch, - 03/17/25 at breakfast and lunch, - 03/26/25 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, - 04/22/25 at breakfast and lunch, - 05/10/25 at breakfast and lunch, and - 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..." 3.1-46(a)(1)			
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy			

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	155797	A. BUILDING 00 B. WING	05/13/2025

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Bldg. 00	Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure medications were available for 1 of 15 residents reviewed for pharmacy services. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, indicated the 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. A physician's order, dated 11/24/24 through 02/25/25, indicated the resident was to receive tramadol (a pain medication) 50 milligrams, twice a day from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. The January 2025 Electronic Medication Administration Record indicated the resident had not received the medication on the following dates and times: - On 01/22/25 from 6:00 P.M. to 10:00 P.M., the resident's medication was not administered due to the medication being unavailable. - On 01/24/25 from 6:00 A.M. to 10:00 A.M., the resident's medication was not administered due to the medication being unavailable and the resident needed a new prescription. - On 01/25/25 from 6:00 A.M. to 10:00 A.M., the resident's medication was not administered due to	F 0755	Resident 26 has had no adverse effects from said deficient practice. No other residents were affected. All residents with regularly ordered narcotic pain medications were audited for proper administration as ordered. Licensed clinical staff were in serviced regarding what to do when an ordered medication is not present in the med cart. 2 residents with regularly ordered narcotic pain medication will be audited for proper administration by DHS/ADHS/designee as ordered and available 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	05/31/2025

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	the medication being unavailable. - 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 unavailable. - On 01/28/25 from 6:00 P.M. to 10:00 P.M., the resident's medication was not administered due to the medication being unavailable. - On 01/29/25 from 6:00 A.M. to 10:00 A.M., the resident's medication was not administered due to the medication being unavailable. A Physician Progress Note, dated 01/21/25, indicated the resident was seen by the Nurse Practitioner with no indication a new prescription was needed for the tramadol. The resident was being seen for having recurring abdominal discomfort and a gallbladder ultrasound order. A Progress Note, dated 01/25/25 at 7:45 P.M., indicated the resident was out of Tramadol and needed a new prescription. The writer went to the nurse to request to the provider for a 3-day supply. The request was placed in the provider book at the 200 Hall nurse's station. A Physician Progress Note, dated 01/27/25 at 6:11 A.M., indicated the resident was seen by the Nurse Practitioner. The note lacked any indication that the resident needed a new prescription for tramadol. A Progress Note, dated 01/29/25 at 8:10 A.M., indicated a message was sent to the Nurse Practitioner requesting a hard script for tramadol. During an interview, on 05/12/25 at 9:18 A.M., RN 15 indicated when a resident was out of a			

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	medication that required a prescription they could pull one emergency dose from the emergency drug kit. They would need to call the physician to get a prescription sent to the pharmacy. They should have a new prescription within 24 hours. If nursing staff communicated with the physician related to medications being unavailable, it should be documented in a progress note. The current facility policy titled, "Guidelines for Medication Orders", with a review date of 12/17/24 was provided by the Director of Nursing on 05/12/25 at 3:01 P.M. The policy indicated, "...The purpose of the policy it to establish uniform guidelines in the receiving and recording of medication orders..." The current facility policy titled, "Medication Ordering and Receiving from Pharmacy", with a revised date of 11/18, was provided by the Director of Nursing on 05/12/25 at 3:01 P.M. The policy indicated, "...Reorder medication several days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand..." 3.1-25(a)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on observation, interview, and record review, the facility failed to ensure medications were administered appropriately to prevent significant medication errors for 1 of 3 residents reviewed for significant medication errors. (Resident 23) Findings include:	F 0760	Resident 23 was assessed for any adverse effects from said deficient practice. Her lab value was within normal limits. Her potassium was changed to a liquid form. All residents with medications that should not be crushed can be at risk potentially.	05/31/2025

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	QMA 9 was observed preparing medications for Resident 23 on 05/12/25 at 8:48 A.M. QMA 9 sanitized her hands and opened the plastic packages that contained the resident's various medications and placed the medications in a cup. The medications included, but were not limited to, a 20 milliequivalent (mEq) Extended Release (ER) Potassium Chloride tablet. QMA 9 indicated the resident took her medications crushed. She removed a soft gel vitamin supplement tablet from the medication cup and indicated the gel tablet couldn't be crushed. She poured the remaining medications into a clear packet and crushed them with the pill crusher on the medication cart. She poured the crushed medications back into the cup, added pudding and the gel tablet to the cup, and preceded to administer the medications to the resident. During an interview, on 05/12/25 at 9:09 A.M., QMA 9 indicated there were several medications that were not allowed to be crushed because of the coating on the medications. There was a "do not crush" list on the medication cart. She reviewed the list and indicated the potassium chloride table she administered to the resident was on the do not crush list. She was not aware that it was not to be crushed. She learned something new. The resident's clinical record was reviewed on 05/13/25 at 3:50 P.M. A Quarterly Minimum Data Set assessment, dated 03/11/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, coronary artery disease, hypertension, and malnutrition. The resident's most recent laboratory values were reviewed, and her potassium level was within		All residents that take crushed medications were audited for medicines ordered that should not be crushed . Licensed staff, including QMA 9 were in serviced on the “Medications not to be crushed list”. 2 random residents that require crushed medications will be audited by DHS/ADHS/designee for medications that should not be crushed 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	

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	normal limits. The "Medications Not To Be Crushed" list, with a revision date of 12/22, was provided by the Corporate Clinical Support Nurse on 05/13/25 at 3:30 P.M. The list indicated the Potassium Chloride tablet was not to be crushed because it was an extended-release medication. 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to appropriately store medications for 1 of 3 medication carts reviewed (100 Hall Medication Cart). Findings include: On 05/13/25 at 1:13 P.M., the 100 Hall Medication Cart was observed with RN 10 and contained the following: - A Basaglar insulin pen for Resident 30. The pen was 1/2 full and was not labeled with an "opened on" date, and - A 198-milliliter bottle of liquid fish oil for Resident 30. The bottle was two-thirds full and was not labeled with an opened-on date. During an interview, on 05/13/25 at 1:18 P.M., RN 10 indicated the resident received 32 units of the insulin twice a day and received 2.5 ml of the fish oil daily. Both medications should have been labeled with opened on dates. The Basaglar insulin pen package insert indicated,	F 0761	Resident 30 had no adverse effects from said deficient practice. The insulin pen and the fish oil were discarded and new were available to give. All residents with medications stored in the med cart have the potential to be affected. All medication carts were audited for opened insulin or liquids without open dates. Licensed staff were educated regarding writing open dates on all liquid medications and insulins. 2 Random med cart audits will be conducted by DHS/ADHS/Designee to ensure the absence of opened liquid medications or insulin pens without open dates 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months.	05/31/2025

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	"...Throw away all insulin...in use after 28 days, even if there is insulin left..." The current facility policy, titled "MEDICATION STORAGE IN THE FACILITY", with a revision date of 11/18, was provided by the Corporate Clinical Support Nurse on 05/13/25 at 3:15 P.M. The policy indicated, "...When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated...a "date opened" sticker shall be placed on the medication..." 3.1-25(o)		The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on record review, interview, and observation, the facility failed to follow infection control guidelines related to infection tracking and trending, and Enhanced Barrier Precautions (EBP) related to infection control. (Residents 10 and 40) Findings include: 1. During a review of the Infection Control Tracking and Trending documentation on 05/13/25 at 10:08 A.M., The facility lacked documented tracking of antibiotic use for February and March 2025. During an interview on 05/13/25 at 3:35 P.M., the Infection Preventionist indicated she came to this facility in April and infections and antibiotic usage was not tracked in February and March. The current facility policy titled, "Infection Prevention and Control Program" with a review date of 12/17/24, was provided by the	F 0880	The facility established an effective infection control tracking and trending system per guidelines. Resident 10 and resident 40 had no adverse effects from said deficient practice EBP related. All residents requiring EBP and antibiotic trending and tracking have the potential to be affected. Staff were educated on EBP and how and when to apply these precautions (including RN 7 and RN 8). The tracking and trending system will be audited by the DHS/ADHS/Designee for completion with antibiotics ordered 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly	05/31/2025

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	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 infections...The campus has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases...The campus shall designate a member of the clinical team to monitor the campus...program 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.		for 3 months. Random care audits for residents that require EBP will be conducted by the DHS/ADHS/Designee 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	

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	During an interview, on 05/12/25 at 2:12 P.M., RN 7 indicated nursing staff should wear gloves and a gown when providing direct care for residents who are in EBP. She should have worn a gown when she was touching the wound dressing for Resident 10. 3. Resident 40's clinical record was reviewed on 05/07/25 at 3:09 P.M. A Significant Change MDS assessment, dated 03/17/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, non-Alzheimer's dementia, and peripheral vascular disease. The resident had pressure ulcers and venous ulcers that were present on admission. The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 04/29/25, that indicated the resident was in EBP and staff were to wear a gown and gloves at minimum during high-contact care activities. During an observation, on 05/12/25 at 1:21 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 and RN 8 entered the resident's room and proceeded to cleanse and administer wound care treatments to the resident's multiple wounds without donning gowns. During an interview, on 05/12/25 at 2:12 P.M., RN 7 indicated nursing staff should wear gloves and a gown when providing direct care for residents who are in EBP. She should have worn a gown during the wound dressing changes for Resident 40.			

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	The current facility policy, titled "Enhanced Barrier Precautions (EBP) Standard Operating Procedure", dated 04/01/24, was provided by the DON on 05/12/25 at 3:01 P.M. The policy indicated, "...EBP will be in place during high-contact care activities for residents with the following conditions...All Residents with chronic wounds, including but not limited to, pressure ulcers...at minimum, staff shall wear gloves and gowns during high-contact care activities..." 3.1-18(b)			
F 0947 SS=E Bldg. 00	483.95(g)(1)-(4) Required In-Service Training for Nurse Aides Based on record review and interview, the facility failed to ensure the staff had the required six hours of dementia training within six months of hire and three hours annually for 3 of 10 employee records reviewed. (CNA 2, CNA 3, and CNA 5) Findings include: The employee records were provided by the Employee Experience Manager on 05/08/25. The following staff members, working on the skilled unit failed to have the required number of hours of dementia training prior to working with residents that had a diagnosis of dementia: - Certified Nurse Aide (CNA) 2 was hired on 06/19/24 and had 1.5 hours of dementia training, - CNA 3 was hired on 12/20/24 and had 1 hour of dementia training, and - CNA 5 was hired on 10/16/24 and had 1.5 hours of dementia training.	F 0947	CNA 2 CNA 3 and CNA 5 Employees that have not had the initial 6 hours of dementia training or 3 hours of annual dementia training will be taken off schedule until they achieve their needed training. Staff educated on the requirements and need for this training. Staff that has not had this training is taken off schedule until achieved. 3 Random audits of the annual and initial dementia training will be audited by the BOM/ED/designee 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly for 3 months. The results of these audits will be	05/31/2025

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	During an interview, on 05/09/25 at 11:13 A.M., the Employee Experience Manager indicated she had provided all the documented dementia training in the employee files. Reports were sent to the staff through email, and it was their responsibility to complete the training. The department managers received a report indicating which staff members still had training to complete. The department managers were to follow up with their staff. She believed new staff members were to have six hours of dementia training and was unsure of older employees. During an interview, on 05/09/25 at 11:28 A.M., Corporate Clinical Support Nurse indicated the facility did not have a policy related to dementia training they would follow State and Federal regulations. 3.1-14(u)		reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 6, 7, 8, 9, 12, and 13, 2025. Facility number: 012854 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 16, 2025.	R 0000	This submission of the plan of correction does not indicate an admission by Aspen Place Health Campus that the findings and allegations contained herein are accurate and true representations of the care and services provided to the residents of Aspen Place Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility herein maintains it is in substantial compliance with the requirements	

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			of participation for comprehensive health care facilities. (for Title 18/19 programs). Attached you will find our Plan of Correction for Aspen Place Health Campus for our annual survey conducted on May 13th, 2025. We initiated immediate interventions when concerns were identified on this date. We respectfully request desk review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 527-2222. Sincerely, Mikayla Schneider, Executive Director	
R 0087 Bldg. 00	410 IAC 16.2-5-1.3(b)(1-3) Administration and Management - Noncompliance Based on record review and interview, the facility failed to ensure the staff had the required six hours of dementia training within six months of hire and three hours annually for 3 of 10 employee records reviewed. (CNA 2, CNA 3, and CNA 5) Findings include: The employee records were provided by the Employee Experience Manager on 05/08/25. The following staff members working on an assisted living demenita unit failed to have the required number of hours of dementia training: - Certified Nurse Aide (CNA) 2 was hired on 06/19/24 and had 1.5 hours of dementia training, - CNA 3 was hired on 12/20/24 and had 1 hour of dementia training, and	R 0087	CNA 2 CNA 3 and CNA 5 Employees that have not had the initial 6 hours of dementia training or 3 hours of annual dementia training will be taken off schedule until they achieve their needed training. Staff educated on the requirements and need for this training. Staff that has not had this training is taken off schedule until achieved. 3 Random audits of the annual and initial dementia training will be audited by the BOM/ED/designee 3 times a week for 4 weeks, 1 time a week for 4 weeks, every other week for 4 weeks, monthly	05/31/2025

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	05/13/2025

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
	- CNA 5 was hired on 10/16/24 and had 1.5 hours of dementia training. The as worked schedule was reviewed for the survey period and it indicated CNA 2 worked on the dementia unit on 05/06/25 and CNA 3 worked on the dementia unit on 05/12/25. During an interview, on 05/09/25 at 11:13 A.M., the Employee Experience Manager indicated she had provided all the documented dementia training in the employee files. Reports were sent to the staff through email, and it was their responsibility to complete the training. The department managers received a report indicating which staff members still had training to complete. The department managers were to follow up with their staff. She believed new staff members were to have six hours of dementia training and was unsure of older employees. During an interview, on 05/09/25 at 11:28 A.M., Corporate Clinical Support Nurse indicated the facility did not have a policy related to dementia training they would follow state and federal regulations.		for 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Findings will be reviewed during the campus monthly QAPI meeting in to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation as to the monitoring plan.	