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	03/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaint IN00402207. This visit included the Investigation of Residential Complaint IN00401666. Complaint IN00402207 - No deficiency related to the allegation is cited. Complaint IN00401666 - State deficiency related to the allegation is cited at R0029. Unrelated deficiency cited. Survey dates: February 28 and March 1, 2023 Facility number: 012854 Provider number: 155797 AIM number: 201104690 Census Bed Type: SNF/NF: 30 SNF: 25 Residential: 17 Total: 72 Census Payor Type: Medicare: 18 Medicaid: 29 Other: 8 Total: 55 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 7, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted on February 28, 2023 and March 1, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 2, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Back	Clinical Support	03/31/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observation, and record review, the facility failed to follow the Emergency Preparation Plan or use a Hoyer lift to transfer a resident, who required the extensive assistance of two staff and a Hoyer lift for transfers, resulting in a fracture for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/28/23 at 2:45 p.m. A Quarterly MDS (Minimum Data Set) assessment, dated 12/10/22, indicated the resident was severely cognitively impaired. She required extensive assistance of two staff for mobility, transfer, and ADLs (Activities of Daily Living). The diagnoses included, but were not limited to, dementia, heart disease, weakness, and morbid obesity. A current Care Plan for Resident B, with an intervention approach date of 11/20/19, indicated the resident required extensive assistance with a Hoyer lift for transfers, two staff assistance with bed mobility, and extensive assistance with a Hoyer lift for toileting. A physician's order, dated 2/27/23, indicated the	F 0689	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident B was affected by the alleged deficient practice. Resident B sent to ER for medical evaluation and treatment. Resident returned to facility after treatment. Resident B Care Plan reviewed and updated as appropriate. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All like residents who require lifts for transfer have the potential to be affected. All like residents Care Plans were reviewed and updated accordingly. Staff that provide care were in-serviced on the policy and procedure of resident transfers and the guidelines for residents using a lift. Staff members educated on Emergency	03/02/2023

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	staff were to obtain a 2-view x-ray to the left shoulder. A Progress Note, dated 2/28/23 at 2:53 a.m., indicated Resident B returned from the ED (Emergency Department) with a diagnosis of a fracture of the proximal end of the left humerus and a fracture of the surgical neck of left humerus. A Patient Report for Resident B, dated 2/27/23, indicated the resident had an X-ray of the left shoulder. There was an acute impacted proximal humeral fracture at the surgical neck. There was an avulsion fragmentation of the greater tuberosity. A Progress Note, dated 2/27/23 at 1:30 p.m., indicated Resident B was sitting in her recliner in her room; a tornado warning was called for the city. Resident B asked to be moved out her room for the warning. She required the use of a Hoyer lift; but due to the eminent weather conditions, the staff had used three staff to assist her to her wheelchair, to move her to an area of safety. When assisting the resident back to her room after the warning was canceled, the resident started to complain of pain in her left shoulder. The area was examined, and an abnormal alignment was noted. The Point of Care ADL (Activities of Daily Living) indicated the resident required extensive assistance or total dependence for the following dates and times: - On 2/26/23 at 11:20 a.m., total dependence of two or more staff members and a mechanical lift, - On 2/26/23 at 5:22 p.m., total dependence of two or more staff members and a mechanical lift, - On 2/25/23 at 9:40 a.m., extensive assistance of		Operations Plan (Emergency Preparations Plan) o Guidelines for Resident Utilizing a Lift Policy o Resident Transfer Standard Operating Procedures o Return demonstration for proper mechanical lift procedure o Emergency Operations Plan **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - As a measure of ongoing compliance, DHS or designee will audit to ensure proper Hoyer transfers are being done according to lift status, audit of like residents 3xs weekly x 1 month, 2xs weekly x2 months and then Every other weekly x 3 month as appropriate. - As a measure of ongoing compliance, DHS or designee will perform mock simulation to ensure proper assessment of residents for safe shelter during severe weather and/or tornados are being done according to the Emergency Operations Plan, 3xs weekly x 1 month, 2xs weekly x2 months and then Every other week x 3 month as appropriate. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	

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	one staff member and a transfer aid, - On 2/25/23 at 5:55 p.m., extensive assistance of one staff member and a mechanical lift, and - On 2/24/23 at 9:16 p.m., extensive assistance of one staff member and a mechanical lift. During an interview on 2/28/23 at 11:18 a.m., the DON (Director of Nursing) indicated on 2/27/23 there was a tornado warning. During the tornado warning Resident B was transferred from a recliner to a wheelchair by three CNA's (Certified Nursing Aide) and a QMA (Qualified Medication Assistant) to assist her to an area of safety, resulting in fractures of the proximal end of the left humerus and surgical neck of the left humerus. Resident B was a Hoyer lift, but the Hoyer was not available, so they manually transferred her. She was sent out to the hospital. During an interview on 2/28/23 at 11:23 a.m., CNA 2 indicated the tornado sirens were going off, and Resident B wanted to get up from her recliner in her room, into the wheelchair, to move to the hall. CNAs 3, 4, and QMA 5, assisted with a manual lift of Resident B. There was a Hoyer pad under her. CNA 2 grabbed the strap on one side, CNA 3 grabbed the strap on the other side and the QMA grabbed the straps between her legs. They lifted her up, turned her, and CNA 4 positioned the wheelchair under her. Resident B only complained of leg pain at that time. The resident had no complaints about her arm when she was in the hallway. After the "all clear" was announced, they returned the resident to her room, used the Hoyer to place the resident in her recliner. At that time, she complained of arm pain and was unable to lift her left arm. CNA 2 was able to feel the separation in the bone of the arm and immediately reported it. Resident B was sent out to hospital.		**program will be put into place?** - DHS/ADHS/designee will be responsible for monitoring proper mechanical lift transfer procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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	During an interview on 2/28/23 at 11:35 a.m., the DON indicated there were two Hoyer lifts in the building. There was one Hoyer lift for the 200 Hall for seven residents that required a Hoyer lift transfer, and the other Hoyer lift was shared between the 100 and 300 Halls for two residents that required a Hoyer lift transfer on the 100 Hall. During an interview and observation on 2/28/23 at 1:29 p.m., the DON indicated Resident B had osteopenia. The Regional Clinical Support (RCS) indicated when the staff transferred the resident, they used the Hoyer pad and had an arm under each arm of the resident. The RCS had asked CNA 2 to demonstrate the transfer of Resident B. He sat in a chair with a Hoyer pad under him, CNA 2 indicated she was on the right side of the resident and another CNA was on the left. Both CNAs placed an arm under the RCS arms on each side and used both hands to hold the pad strap while the DON used the straps between the RCS's legs. They then stood him up, pivoted him to the left, and the third CNA placed a rolling chair under him. During an interview on 3/1/23 at 1:07 p.m., CNA 6 indicated if a resident required the use of a Hoyer lift, staff could not transfer them manually. She had checked on Resident B five minutes before she was manually transferred during the tornado warning. The resident said she was fine, and the CNA closed the curtains and gave her a blanket to cover herself. There was a lot of chaos, and everyone was over talking each other. Things needed to be a lot calmer and she had never completed a code black warning drill before. During an interview on 3/1/23 at 1:17 p.m., Licensed Practical Nurse (LPN) 7 indicated if a resident required the use of a Hoyer lift, it would			

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	not be appropriate to transfer by a manual lift. During an interview on 3/1/23 at 1:20 p.m., CNA 8 indicated if a resident required the use of a two person Hoyer lift, it would require two people and the lift. It would not be appropriate to manually lift them. The current facility policy titled "Emergency Operations Plan" and dated 11/1/17, was provided by the Administrator on 2/28/23 at 2:38 p.m. The policy indicated, "...Severe Weather and Tornado ...3. In the event of a Tornado Warning ...B ...ii. If residents ...cannot quickly get up, move ...as far away from the window as possible with the privacy curtains pulled around them and blankets on them ..." The current facility policy titled "Hoyer User Instruction Manual" and dated 2014, was provided by the RCS on 3/1/23 at 10:27 a.m. The policy indicated, "...Statement of Intended Use ...The intended us of this lifting devise is for the safe lifting and transfer of an individual from one resting surface to another ..." The current facility policy titled "Guidelines for resident utilizing a lift" and dated 5/11/17, was provided by the RCS on 3/1/23 at 10:27 a.m. The policy indicated, "...Purpose: To ensure the safety of residents and staff when performing lift transfer task ...Procedures: ...3. Staff should seek the assistance of a second person for those residents' care planned for assistance of two with the lifting device ..." 3.1-45(a)(2)			
R 0000				

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Bldg. 00	This visit was for the Investigation of Residential Complaint IN00401666. This visit included the Investigation of Nursing Home Complaint IN00402207. Complaint IN00401666 - State deficiency related to the allegation is cited at R0029. Complaint IN00402207 - No deficiency related to the allegation is cited. Survey dates: February 28 and March 1, 2023 Facility number: 012854 Residential Census: 17 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on March 7, 2023.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted on February 28, 2023 and March 1, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 2, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interviews and record review, the facility failed to ensure residents were treated with dignity and respect for 2 of 6 residents reviewed for dignity. (Residents H and K) Findings include: 1. During an interview on 2/28/23 at 4:32 p.m., Resident H indicated she did not always get what	R 0029	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of	03/16/2023

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	she thought she should. She indicated if she asked for ice water, she would be told to get her own ice water. She indicated there was a nurse who was grumpy and rude, but she did not want to say who, and did not want to cause any trouble. 2. During an interview on 3/1/23 at 1:34 p.m., Resident K indicated she had called for help to go to the bathroom because her wheelchair had been moved away from the bed and was over near the window. The evening shift nurse came in and said, "We are short Staffed." and she did not help her to the bathroom. During an anonymous interview, from February 28 to March 1, 2023, a staff member indicated she witnessed LPN 11 being rude and disrespectful to the residents all the time. The nurse would not give the residents ice water and had heard the nurse say, "Shut up and get it yourself." One resident had asked the nurse to help her with her bed clothes, and LPN 11 said, "Do it yourself or wait for your favorite CNA." The current facility policy titled "Resident Rights" and with a revision date of 8/11/16, was provided by the Regional Clinical Support on 3/1/23 at 11:18 a.m. The policy indicated, "...Purpose: To ensure resident rights are respected ...Procedures: 2. Our residents have a right to ...a. be treated with dignity and respect ..." This State tag relates to complaint IN00401666.		Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted February 28, 2023, through March 1, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 16, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. **R0029 – Residents' Rights - Deficiency** *"Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for 2 of 6 residents reviewed for dignity. (Residents H and K)* It is the practice of this provider to ensure residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident H and K were affected by the alleged deficient practice. - Residents H and K were assessed immediately for any adverse outcomes, with none noted.	

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			2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All residents have the potential to be affected by the alleged deficient practice. - Clinical staff were in-serviced on: o Resident Rights Policy o Trilogy Service Standards **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will conduct random audits in person or through resident concern process on 3 residents x3 days a week for 4 weeks, then 2 days a week x8 weeks then weekly times x3 months to ensure residents rights are respected including residents' dignity and respect. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - DHS or designee will be responsible for monitoring compliance of residents for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold	

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			of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 03/16/2023	