STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00428620. Complaint IN00428620 - Federal/State deficiencies related to the allegations are cited at F677, F725 and F744. Survey dates: February 19, 20, 21, and 22, 2024. Facility number: 002657 Provider number: 155681 AIM number: 200308930 Census Bed Type: SNF/NF: 43 SNF: 36 Total: 79 Census Payor Type: Medicare: 25 Medicaid: 26 Other: 28 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 1, 2024.	F 0000	Autumn Woods Annual/Complaint 2024 Plan of Correction The submission of this plan of correction does not indicate an admission by Autumn Woods Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Autumn Woods Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dalyn Miller	Division Vice President	03/15/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure showers were provided consistently for 4 of 4 residents reviewed for ADL (Activities of Daily Living) care. (Residents F, C, D, K) 1. The record for Resident F was reviewed on 2/21/24 at 11:03 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, immobility syndrome, morbid obesity, muscle weakness, abnormalities of gait and mobility, difficulty walking, and spinal stenosis. The care plan, dated 5/16/22, indicated the resident required staff assistance to complete ADL tasks completely. The Profile Care Guide care plan, dated 5/20/22, indicated the resident received showers on Tuesdays and Fridays and used a full body mechanical lift for transfers. The Quarterly MDS (Minimum Data Set) assessment, dated 1/26/24, indicated the resident was moderately cognitively impaired, had limited range of motion in both of his lower extremities, and was dependent on a helper for showering and bathing. The shower documentation for January 2024 indicated the resident only received one shower that month on 1/2/24. He received a complete bed bath on 1/5/24, 1/23/24, and 1/29/24. He refused a shower on 1/26/24. There was no further documentation of the resident receiving any showers or supplemental complete bed baths for the rest of the month.	F 0677	F677: ADL Care Provided for Dependent Residents 1 Residents F, C, D, K were affected. Residents were not identified due to their confidentiality being maintained in the statement of deficiencies. Corrective action was taken for all residents as listed below. 2 All residents had the potential to be affected. All residents had a skin assessment and residents with a BIMS of 8 or greater were interviewed to ensure no adverse effects were present. All residents interviewed to determine bathing preference. If residents are unable to state their bathing preference, staff and/or family interviewed, and most recent stated bathing preference reviewed to determine resident's preference. Residents' profile care plans reviewed and updated with the residents' bathing preference. Nursing staff provided education on Resident Care Profiles, Guidelines for Bathing Preference, transfers to shower chairs using a mechanical lift, and documenting ADLs. Facility Assessment reviewed and updated by QAPI committee. Nursing staff provided education on Staffing plan per facility assessment and breakdown of staffing as based upon census and acuity. Education regarding sufficient	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The shower documentation for February 2024 indicated the resident received a shower on 2/5/24. He received complete bed baths on 2/6/24, 2/9/24, 2/13/24, and 2/18/24. There was no further documentation of the resident receiving any showers or supplemental complete bed baths for the rest of the month. During an interview on 2/19/24 at 10:45 a.m., Resident F indicated on 2/16/24 he did not get a bath. He was told staff didn't have time to give him one because they were too short staffed. He had gotten a bath on 2/13/24, but hadn't received one since then. During an interview on 2/22/24 at 3:42 p.m., CNA (Certified Nurse Aide) 1 indicated the resident's shower days were on Tuesday and Friday. They filled out the shower sheets and documented it in the computer system. During an interview on 2/22/24 at 3:53 p.m., CNA 2 indicated they needed more help. Some of the staff got attitudes when they were short staffed and wouldn't do the showers. Residents had reported several times they did not receive their showers. They usually gave Resident F complete bed baths. They didn't usually give showers to residents who were full body mechanical lift lifts because it was kind of dangerous to get them into the showers. She had never given him an actual shower. During an interview on 2/22/24 at 4:00 p.m., CNA 3 indicated she was working on Legacy Lane that day and was the only CNA. That was a typical day for her. She did not feel like there was enough staff because she had 30 dependent residents to		staffing provided to ED and Nursing department leaders which includes review of daily master schedule and hours. Additionally, leaders are assigned routine rounding to check in with staff throughout their shift. Employee Engagement Committee to meet weekly to discuss current staffing levels, new hires, interviews, recruitment needs and retention efforts. Trilogy internal agency staff and staff who “voyage” from nearby Trilogy campuses are also utilized to supplement staff shortages. 3 As a measure of ongoing compliance, the DHS or designee will audit 5 resident records weekly x1 month, every other week x2 months, then monthly x3 months to ensure bathing was performed per the resident’s preference. ED or designee will interview 3 random nursing staff to ensure that they have no concerns about being able to complete their daily assigned duties and 3 random residents with BIMS of 8 or above to ensure that they have no concerns about staffing or the care they are receiving, weekly for 1 month, every other week for 2 months, and monthly for 3 months. 4 As a quality measure, the DHS, ED and/or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care for. They had 2 nurses on the hall as well but no other staff to give care. Sometimes the nurses would help, but not all the time. Sometimes she didn't have time to get all her tasks done. Showers might not get completed. Sometimes toileting wasn't done. She would get to it when she could. They did not have enough staff to supervise the residents. There was usually a couple of times a week she could not get her showers completed. On Mondays she could count on being by herself. She talked to the Director of Nursing about it and was told they didn't have the staff, and nobody wanted to work. During an interview on 2/22/24 at 4:19 p.m., the Regional Director of Clinical Operations (RDCO) indicated showers were given per resident preference. Resident F's preference was to have showers and there was no reason why he couldn't have a shower. Requiring a full body mechanical lift lift did not mean he could not have a shower. During an interview on 2/22/24 at 4:37 p.m., the RDCO indicated the resident's shower in his room had a very high lip to get over and she could see where it could possibly not work with a lift. They were going to see what they could do about the issue. They had it in capital budget to remodel all of the showers, but had not completed it yet. 2. During an interview on 2/19/24 at 9:30 a.m., Resident C indicated she was not receiving her showers on the days she was supposed to. Either she didn't get her shower at all or once a week and not on the day she was supposed to get her showers. The record for Resident C was reviewed on 2/22/24 at 3:45 p.m. The diagnoses included, but were not limited to, bilateral primary osteoarthritis of knee, idiopathic gout, unspecified		Performance Improvement meetings. The plans will be revised as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	osteoarthritis, spinal stenosis, lumbar region without neurogenic, and difficulty in walking. The Quarterly MDS, dated 11/9/23, indicated the resident was moderately cognitively intact. She was totally dependent on staff for her showers. The care plan, dated 2/15/24, indicated Resident C had the potential for decline in her ADLs related to decreased mobility. The interventions included, but were not limited to, encourage the resident to do as much for herself as safely possible and observe for a decline and report as needed. The review of the shower record indicated the following: January 2024 - On 1/2/24 the resident received a shower. - On 1/5/24 the resident received a shower. - On 1/29/24 the resident received a shower. The resident was scheduled to receive a shower every Tuesday and Thursday. February 2024 The shower record lacked documentation which indicated the resident had received a shower. 3. During an interview on 2/20/24 at 10:00 a.m., Resident D indicated he was unable to take a shower due to his driveline pump and his dialysis catheter. He was supposed to get a complete bed bath on Wednesday evening and a partial bath the other days, but sometimes it was hard to get a bath because there wasn't enough staff. When he did get his bed bath, it was usually late and that was his dialysis day and he usually went to bed early because he was tired. The record for Resident D was reviewed on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/22/24 at 4:14 p.m. The diagnoses included, but were not limited to, infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, methicillin resistant staphylococcus aureus infection, cutaneous abscess, acute respiratory failure with hypoxia, atrial fibrillation, hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, chronic pulmonary edema, type 2 diabetes mellitus with diabetic, insomnia, unsteadiness on feet, difficulty in walking, acquired absence of left leg below knee, presence of heart assist device, dependence on renal dialysis, chronic respiratory failure with hypoxia, and cardiogenic shock. The Quarterly MDS, dated 12/19/23, indicated the resident was cognitively intact. He required supervision while bathing. The care plan dated 3/27/23, indicated Resident D had the potential for a decline in ADLs. The interventions included, but were not limited to, provide nail care on shower days and as needed, offer facial shaving on shower days, as needed, or as requested. Notify nursing of refusals. The shower record, indicated the following: January 2024 - On 1/21/24 no documentation of a bath - On 1/22/23 the activity did not occur - On 1/23/24 the activity did not occur - On 1/25/24 the activity did not occur - On 1/26 24 the activity did not occur - On 1/28/24 the activity did not occur - On 1/30/24 the activity did not occur - On 1/31/24 the activity did not occur February 2024 - On 2/1/24 the activity did not occur			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On 2/2/24 the activity did not occur - On 2/5/24 the activity did not occur - On 2/6/24 the activity did not occur - On 2/7/24 the activity did not occur - On 2/8/24 the activity did not occur - On 2/9/24 the activity did not occur - On 2/11/24 the activity did not occur - On 2/13/24 the activity did not occur - On 2/16/24 the activity did not occur - On 2/18/24 the activity did not occur - On 2/19/24 the activity did not occur - On 2/22/24 the activity did not occur 4. During an interview on 2/20/24 at 10:05 a.m., Resident K indicated she was not getting her showers. The record for Resident K was reviewed on 2/23/24 at 9:39 a.m. The diagnoses included, but were not limited to, a lesion at T11-T12 level of the thoracic spinal cord, concussion and edema of the thoracic spinal cord, spinal stenosis, spondylosis, wedge compression fracture of the first lumbar vertebra, dementia, anxiety, and the need for assistance with personal care. The Quarterly MDS assessment, dated 10/24/23, indicated the resident was cognitively intact. She was dependent on staff for showers and partial baths. The care plan, dated 2/22/24, indicated Resident K had the potential for a decline in ADLs. The interventions included, but were not limited to, provide nail care on shower days. The shower records indicated the following: December 2023 - On 12/7/23 the resident received a shower - On 12/9/23 the resident received a shower			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On 12/14/23 the resident received a shower - On 12/18/23 the resident received a shower - On 12/21/23 the resident received a shower - 19 days were bed baths January 2024 Documentation indicated the resident did not have a shower in January The resident had 16 partial baths Nine days where the activity did not occur One day the bath was not recorded February 2024 - On 2/1/24 the resident received a shower - On 2/5/24 the resident received a shower - On 2/8/24 the resident received a shower - On 2/15/24 the resident received a shower - On 2/20/24 the resident received a shower The resident had 9 partial baths Review of the facility's current policy on "Guidelines for Bathing Preference" included, but was not limited to, "...4. Bathing shall occur at least twice a week unless resident preference states otherwise..." Cross Reference with F725 and F744 This citation relates to Complaint IN00428620 3.1-38(a)(3)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	preferences. Based on record review and interview, the facility failed to ensure post-dialysis monitoring of a dialysis access site for 1 of 1 resident's reviewed for dialysis. (Resident D) Findings include: The clinical record for Resident D was reviewed on 2/21/24 at 08:46 a.m. The diagnoses included, but were not limited to, infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, and dependence on renal dialysis. The Quarterly MDS (Minimum Data Set) assessment, dated 12/19/23, indicated the resident was cognitively intact. The care plan, initiated on 9/8/21, indicated the resident had renal failure resulting in a need for dialysis. The interventions included, but were not limited to, assess access site for signs of localized infection such as swelling, redness, pain or tenderness, heat at the area, purulent drainage, bloody/malodorous dialysate and observe catheter site per orders. The Registered Dietician dialysis note, dated 2/13/24 at 3:49 p.m., indicated the resident attended hemodialysis three times per week and he was on a 1200 cc (cubic centimeter) fluid restriction. The post dialysis observation forms, dated 1/10/24 through 2/16/24, lacked documentation which indicated staff monitored the resident's shunt site for signs and symptoms of	F 0698	F698 Dialysis 1 Resident D had the potential to be affected by the alleged deficient practice. Resident D had dialysis access site assessed with no signs of complication noted. 2 No other residents were affected. No other residents receive dialysis. Nurses were provided education on Guidelines for Dialysis. 3 As a measure of ongoing compliance, the DHS or designee will audit all residents on dialysis to ensure post dialysis monitoring of dialysis access site was completed, weekly x 1 month, then every other week x2 months, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised as warranted.	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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

complications.

During an interview on 2/22/24 at 8:47 a.m., the ED (Executive Director) indicated staff should be monitoring the resident post dialysis.

During an interview on 2/22/24 at 10:24 a.m., the DON (Director of Nursing) indicated the dialysis resident would be monitored for complications. The shunt would be monitored for complications and documented in the post dialysis section.

During an interview on 2/22/24 at 10:39 a.m., RN 14 indicated when a resident returned from dialysis, staff would monitor the shunt for edema, bleeding, pain, and vital signs. The post dialysis would be documented in the clinical record under observations.

During an interview on 2/22/24 at 1:45 p.m., RN 15 indicated when a resident returned from dialysis, she would do an assessment and monitor the resident's shunt for bleeding, infection, redness, edema, and pain. She would also check the residents vital signs.

The facility's current policy on "Guidelines for Dialysis" included, but was not limited to, "...5. Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring of the shunt site for signs of complication b. Review the Dialysis Provider paperwork for any necessary follow up requirements... 7. Monitor the AV fistula/graft/central venous catheter daily and document in resident medical record. a. If abnormal bleeding is noted apply pressure to area and call 911 for transfer to the hospital..."

3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure there were enough staff to assist residents with activities of daily living in a timely manner related to bathing, incontinence care, and falls related to sufficient staffing. This deficient practice had the potential to affect 79 of 79 residents residing in the facility. Findings include:	F 0725	F725 Sufficient Nursing Staff 1 Residents M, G, N, C, D, K, E, F were not able to be identified, however all residents are addressed in the following measure. 2 All residents had the potential to be affected by the alleged deficient practice. All	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	During an interview on 2/20/24 at 9:30 a.m., the DON (Director of Nursing) indicated staffing was based on the budget and acuity. They would then adjust as needed. If there were call-ins, they attempted to get coverage, but if they were not able to fill the shift, then leadership management would cover the shift, even if it was the CNA (Certified Nurse Aide) position. They haven't had any more than the usual call outs by staff. She indicated the following staff were scheduled: - Legacy Lane (200 and 300 Halls), were staffed with two nurses and three CNAs for both day and night shifts. They usually staffed twelve-hour shifts, but some staff worked eight-hour shifts. - The 100 Hall was staffed with one nurse and one CNA for all three shifts. The hall usually held 14 residents, but was rarely full and with the semi-private rooms, they only put one resident in those rooms. - The 400/500 Halls were staffed with two nurses and four CNAs for all shifts. During an interview on 2/20/24 at 4:22 p.m., RN 5 indicated nursing staff had to do laundry at times. Both the CNAs and nurses were short staffed in the facility. There was at times one CNA for 40 residents and residents who needed assistance with eating were not receiving help. During an observation of the Legacy Hall on 2/21/24 at 9:22 a.m., Resident M assisted female Resident L to stand up from her recliner to her walker. Six residents joined in the raising and swinging their arms to exercise with music playing at 9:38 a.m. There were sixteen residents in the common area. Five residents were awake and watching. The rest were asleep. At 9:40 a.m.,		residents had a skin assessment and residents with a BIMS of 8 or greater were interviewed to ensure no adverse effects were present. Education was provided to the staff regarding call offs and how it affects the facility, the residents, and their peers by the ED. Facility Assessment reviewed and updated by QAPI committee. Nursing staff provided education on Staffing plan per facility assessment and breakdown of staffing as based upon census and acuity. Education regarding sufficient staffing provided to ED and Nursing department leaders which includes review of daily master schedule and hours. Additionally, leaders are assigned routine rounding to check in with staff throughout their shift. Employee Engagement Committee to meet weekly to discuss current staffing levels, new hires, interviews, recruitment needs and retention efforts. Trilogy internal agency staff and staff who “voyage” from nearby Trilogy campuses are also utilized to supplement staff shortages. 3 As a measure of ongoing compliance, ED or designee will interview 3 random nursing staff to ensure that they have no concerns about being able to complete their daily assigned duties and 3 random residents with BIMS of 8 or above to ensure that they have no concerns about staffing or the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	Resident M stood up and grabbed Activities Aide 6 on the side of her left breast. Resident M indicated he saw another spot to grab. The Activities Aide laughed at him without saying it was inappropriate behavior. One resident sat by herself in the dining room with a cup of coffee in front of her. The Activities Aide 6 kept watching for Resident M to make sure when she raised her arms, he was not by her. Resident M was in the hall talking to the staff at 9:52 a.m. Three staff were standing in the hall talking to each other and a family member, on the 200 Hall at 9:54 a.m. The Activities Aide 6 brought up 4 times to residents that she was watching Resident M to the other residents. The exercise ended at 9:57 a.m. All other staff were in resident rooms at this time. At 10:13 a.m., Resident G was assisted by LPN (Licensed Practical Nurse) 11 to go to her room to the bathroom. There were no CNAs on the halls to assist the residents. Seven residents had fallen asleep in their wheelchairs or recliners. Two nurses were working with the medications and residents. During an interview on 2/21/24 at 9:23 a.m., a family member of Resident N indicated the facility needed more staff. The former activities person kept the resident busy. The residents had not been taken outside for about two years. The type of activities provided wasn't entertaining for the residents. During an interview on 2/21/24 at 9:29 a.m., the Clinical Supervisor 7 indicated there could be call-ins at times. The facility did the best they could to replace the call-ins. They had on-call staff to fill in. She felt that most days they had enough staff to do the one-on-one feedings for residents in their rooms. They always had family available to assist with feeding the residents. No		care they are receiving, weekly for 1 month, every other week for 2 months, and monthly for 3 months. 4 As a quality measure, the ED or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	residents were double briefed, but it had been an issue on the night shift in the past. When they were double briefing residents, they were told that they couldn't do that. It was done to make the next rounding easier, so that there was another brief there. If a resident had a quick decline in their health, the resident could develop MASD (Moisture Associated Skin Damage). The Clinical Supervisor and the Activities Coordinator were observed to be going on and off the unit. During an interview on 2/21/24 at 10:00 a.m., LPN 8 indicated she could finish her work most of the time, but there were times when they were short of staff, and she couldn't complete her ADL (Activities of Daily Living) care. They would have call-ins or staff would not be scheduled to work. She had started her shift to find wet residents. She had not found double briefing of residents recently, but that had been an issue in the past. She had not been asked to work in other halls, but the third shift had to work on the unit and other halls. Harvest Hall had three to four CNAs, Cherry Hall had one CNA, and two CNAs in the unit, but there was usually only one CNA. An upset CNA on the unit would call CNAs who were not on the schedule to work, asking them to come in to help her with resident care. She indicated falls had occurred due to low staffing, because it was hard to keep an eye on all of the residents. During a follow up interview on 2/21/24 at 1:00 p.m., the family member of Resident N indicated at night there were two aides and one nurse and the residents on the unit needed more help than other residents in the building. There seemed to be confusion with residents sometimes in the unit. The facility expected too much out of the staff. During an observation on 2/21/24 at 1:46 p.m., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	Scheduler was working on the 400 Hall as a CNA. She indicated she was just "helping out". During an interview on 2/21/24 at 1:47 p.m., CNA 10 indicated she had worked short staffed. It wasn't normal for the Scheduler to be working on the hall. Falls had occurred on the hall, due to the facility being short staffed. The staff needed more eyeballs on the residents. When there was a hole in the staff schedule, management would only work when there wasn't any other option. Residents had told the CNA that they took themselves to the bathroom, because they knew it would take too long for staff to answer call lights. The CNA informed them that it wasn't a safe thing to do. Four CNAs worked the 400/500 Halls one to two days a week. The rest of the week they worked short staffed. She had to work two halls on occasion. She had also worked in the laundry room, because of short staffing in laundry. Residents would need clothing or sheets and the CNA would go into the laundry room and do the laundry. The call lights went unanswered due to staffing issues. During an observation of the dementia unit on 2/22/24 at 1:15 p.m., there was one nurse and one CNA working on the unit. Three family members were feeding their residents. During an interview on 2/22/24 at 1:53 p.m., LPN 11 indicated the day shift had an aide, the Clinical Supervisor, and herself. This was the usual number of staff. One activities person was also on the hall. She felt work could be completed, but it was tough with one nurse. She felt that falls occurred when staffing was low. Management tried to fill in, but staff called in a lot. It was seldom that beds or residents were wet, but it did occur. The unit did not have to do laundry, but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the environmental staff would step in to do the laundry. There just wasn't enough staff. During an interview on 2/22/24 at 2:09 p.m., CNA 1 indicated she worked her whole shift to get her work completed. She felt sometimes she couldn't spend the time with residents that she should. The residents did have wet or soiled beds at times. There were times of call-ins when illness was in the building. They were sometimes short of staff. During an interview on 2/19/24 at 9:30 a.m., Resident C indicated she was not receiving her showers on the days she was supposed to. Either she didn't get her shower at all once a week and not on the day she was supposed to get her showers. During an interview on 2/20/24 at 10:00 a.m., Resident D indicated he was unable to take a shower due to his driveline pump and his dialysis catheter. He was supposed to get a bed bath on Wednesday evening but sometimes it was hard to get because there wasn't enough staff. When he did get his bed bath it was usually late and that was his dialysis day and he usually went to bed early because he was tired. During an interview on 2/20/24 at 10:05 a.m., Resident K indicated she was not getting her showers. During an interview on 2/20/24 at 10:30 a.m., Resident E indicated she felt like there was not enough staff. She has had to wait up to 45 minutes for her light to be answered. She has had accidents in her pants because staff would not answer her light. The facility failed to provide showers consistently on scheduled and care planned shower days per			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident's preference for Resident F for the months of January and February. During an interview on 2/19/24 at 10:45 a.m., Resident F indicated on 2/16/24 he did not get a bath. He was told staff didn't have time to give him one because they were too short staffed. He had gotten a bath on 2/13/24 but hadn't received one since then. During an interview on 2/22/24 at 3:53 p.m., CNA 2 indicated they needed more help. Some of the staff got attitudes when they were short staffed and wouldn't do the showers. Residents had reported several times they did not receive their showers. They usually gave Resident F complete bed baths. She had not ever given him an actual shower. During an interview on 2/22/24 at 4:00 p.m., CNA 3 indicated she was working on Legacy Lane that day and was the only CNA. That was a typical day for her. She did not feel like it was enough staff because she had 30 dependent residents to care for. They had 2 nurses on the hall as well, but no other staff to give care. Sometimes the nurses would help, but not all the time. Sometimes she didn't have time to get all her tasks done. Showers might not get completed. Sometimes toileting wasn't done. She would get to it when she could. They did not have enough staff to supervise the residents. That was why they had so many falls on the unit. There was usually a couple of times a week she could not get her showers completed. On Mondays she could count on being by herself. She talked to the Director of Nursing about it and was told they didn't have the staff, and nobody wanted to work. The Facility Assessment Tool, reviewed on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/12/24, indicated the facility was licensed to provide care for 91 beds. The average daily census was 81 residents. The average budgeted number of full time LPNs was 13. The average budgeted number of full time nurse aides was 21. The average budgeted number of full time nursing personnel was 5. " ... Campus considers census, resident acuity, resident preferences, and staff competencies to determine the number and competency requirements of staff in order to meet each resident's needs ... Review of some areas include but not exclusive list: 1. The facility assessment to monitor for resident's needs. 2. The number of residents assigned to each staff member. 3. Acuity of the resident on assignment ... 5. Patterns of resident care needs being met: Bathing, toileting needs, call lights response time, resident assisted timely, etc [et cetera]. 6. Staff having to stay late, come in early, or work overtime to complete assigned task. 7. Monitoring for staff appearing rushed during care. 8. Monitor resident for skin tears, bruises, number of incidents, etc ..." Cross Reference with F677 and F744 This citation relates to Complaint IN00428620 3.1-17(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure the	F 0744	F744 Treatment/Service for Dementia	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	monitoring and safety of residents with dementia for 2 of 5 residents reviewed for falls. (Residents B and J). Findings include: 1. The record for Resident B was reviewed on 2/20/24 at 1:40 p.m. The diagnoses included, but were not limited to, a traumatic subdural hemorrhage without loss of consciousness, injury of the face, second degree atrioventricular block, epilepsy, dementia, contusion of part of the head, and repeated falls. The care plan, dated 9/28/22 and revised on 12/29/23, indicated the resident had a traumatic brain injury with a subdural hematoma related to a fall. The interventions included, but were not limited to; dated 9/28/22, allow sufficient time to complete self-care, encourage maximum participation of the resident during self-care activities, monitor for the presence of pain or intolerance during self-care activities, praise the resident for efforts, provide adequate rest periods between self-care activities, provide a private, non-distracting environment for self-care activities. The care plan, dated 9/28/22 and revised 12/29/23, indicated the resident had impaired cognition with associated short term memory impairment and a risk for confusion, disorientation, altered mood, impaired or reduced safety awareness related to dementia. The interventions included, but were not limited to; dated 9/28/22, assess the degree of hearing ability, impulsive behavior and a decrease in visual perception, calm the resident if signs of distress developed during the decision-making process. Determine if decisions made by the resident endanger the resident or others and		1 Residents B and J were not identified, however all residents on dementia care unit are addressed in the following measure. 2 All residents on the dementia care unit had the potential to be affected by the alleged deficient practice. All residents on the dementia care unit had a skin assessment performed. All residents on the dementia care unit had fall care plans reviewed to ensure interventions address root cause of falls, are appropriate for the residents' cognitive status, and have been implemented. Nursing staff provided education on Fall Management Program Guidelines. Facility Assessment reviewed and updated by QAPI committee. Nursing staff provided education on Staffing plan per facility assessment and breakdown of staffing as based upon census and acuity. Education regarding sufficient staffing provided to ED and Nursing department leaders which includes review of daily master schedule and hours. Additionally, leaders are assigned routine rounding to check in with staff throughout their shift. Employee Engagement Committee to meet weekly to discuss current staffing levels, new hires, interviews, recruitment needs and retention efforts. Trilogy internal agency staff and staff who "voyage" from nearby Trilogy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	intervene, if necessary, pay attention to basic needs and provide ADL (activities of daily living) care as required. Provide cues and supervision for decision making, re-direct the resident when agitated behaviors were present or potential for injury was evident. The care plan, dated 9/28/22 and revised 12/29/23, indicated the resident required staff assistance to complete ADL tasks completely and safely. The interventions included, but were not limited to; dated 9/28/22, allow the resident sufficient time to complete all or parts of the task. Do not rush the resident, encourage the resident to do as much as safely possible for self, observe for deterioration in ADL abilities and report if this occurred, provide adequate rest periods between activities, and therapy was to evaluate and treat as needed and ordered. The care plan, dated 9/28/2022 and revised 12/29/23, indicated the resident was at risk for falling related to a history of falls, age, weakness, impaired cognition, and incontinence. The interventions included, but were not limited to; dated 2/16/24, place a pommel cushion to the wheelchair for positioning; dated 8/14/23, provide a touch pad call light; dated 12/9/22 pressure relieving mattress to the bed, apply a mattress on the floor to the bedside. 9/28/22 encourage the resident to assume a standing position slowly, ensure the floor was free of liquids and foreign objects, keep the call light within reach, keep personal items and frequently used items within reach, provide non-skid footwear, staff were to assist the resident with transfers as needed. The Quarterly MDS (Minimum Data Set) assessment, dated 12/20/23, indicated the resident was severely cognitively impaired and was rarely		campuses are also utilized to supplement staff shortages. 3 As a measure of ongoing compliance, ED or designee will interview 3 random nursing staff to ensure that they have no concerns about being able to complete their daily assigned duties and 3 random residents with BIMS of 8 or above to ensure that they have no concerns about staffing or the care they are receiving, weekly for 1 month, every other week for 2 months, and monthly for 3 months. DHS or designee will audit 3 care plans of resident with falls on dementia care unit as available to ensure fall interventions address root cause of falls and are appropriate for resident's cognitive status weekly x 1 month, every other week x 2 months, and monthly x 3 months. 4 As a quality measure, the ED, DHS, or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	or never understood. She was dependent for most mobility and ADLs (Activities of Daily Living). The physician's order, dated 2/17/24, indicated to apply a pommel cushion to the wheelchair and check three times a day. The IDT (Interdisciplinary Team) note, dated 8/14/23 at 11:42 a.m., indicated the resident had an unwitnessed fall while transferring herself out of the bed. The resident denied pain, but she had some bruising to the right knee. The resident was severely cognitively impaired. The current interventions included the pressure reducing cushion, already in place. The new fall intervention was to place a touch pad call light. The nurse's noted, dated 2/15/24 at 8:00 a.m., a CNA (Certified Nurse Aide) indicated the resident had fallen from her wheelchair. The assessment indicated the resident received a hematoma to the left eye, and a laceration to the chin. The resident was awake and responsive, the bleeding was controlled, and her pupils were equal and reactive. The resident's family and the doctor were notified. A new order was received to send the resident to the ER (Emergency Room) for treatment and evaluation of the laceration to the resident's chin. 911 was called and staff remained with the resident until emergency medical services arrived. The nurse's note, dated 2/15/24 at 9:43 p.m., indicated the resident was admitted to the local hospital for 24-hour observation post fall on this day. The IDT note, dated 2/16/24 at 11:52 a.m., indicated the resident had a fall with minor injury on 2/15/24 around 8:30 a.m. The resident was in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her wheelchair, leaning forward, when she fell out of her chair. The resident had a hematoma to the left eye and a laceration to her chin. The resident was sent to a local hospital ER for evaluation and treatment for the laceration to her chin. The resident had cognitive impairment. The current fall interventions were reviewed. The new fall intervention was for a pommel cushion to be placed in the wheelchair for positioning. The nurse's note, dated 2/17/24 at 10:54 a.m., indicated the resident's bruising continued to be dark purple in all areas. The resident had some swelling to her left eye. The resident wasn't complaining of any pain to the area. Staff were to continue to monitor the areas until they healed. The nurse's note, dated 2/20/24 at 12:08 a.m., indicated the sutures were intact to the chin. Bruises and edema remained on the chin, the neck, the left eye, and the left upper arm and elbow. During an interview on 2/21/24 at 9:29 a.m., Clinical Supervisor 7 indicated Resident B's condition was not any different. She had previous falls. When the fall occurred, the aide had put the resident in the high back wheelchair and Resident B's roommate was in the bathroom, so the CNA 12 assisted the roommate. The resident fell forward out of her chair. The Clinical Supervisor wasn't sure when the Dycem was added. The resident required extensive assistance for everything. The CNA should generally have gotten the resident up and sat her up to a table in the dining room. The resident shouldn't have been left upright by herself, but the resident was left sitting in the high back wheelchair, upright instead of reclining. The resident had the pommel cushion in the high back wheelchair since 2/16/24.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	During an observation on 2/21/24 at 9:33 a.m., of the high back wheelchair, the pommel cushion was in the chair with a Dycem on the cushion. During an interview on 2/22/24 at 1:24 p.m., LPN (Licensed Practical Nurse) 11 indicated the resident was not capable of doing anything for herself. When she fell, she was in her room and the aide turned around and the resident fell. The resident had always leaned to one side and was contracted, but the resident went forward in her fall. The interventions prior to the fall were to not let the resident sit upright or alone. The new interventions were for the pommel cushion, and on 2/21/24 the Dycem was to be placed in the wheelchair. The resident had a laceration with sutures on her chin and bruising to the left side of her face. She was not sure if the resident had any other bruising. During an observation of the resident's bruising on 2/22/24 at 1:27 p.m., the resident had a cut to the chin with sutures still in place, bruising to the face, left elbow, upper arm, and to her left breast. During an interview on 2/22/24 at 2:52 p.m., CNA 12 indicated the resident was transferred from her bed to her wheelchair by her. The CNA heard the resident's roommate in the bathroom yelling that she had a bowel movement and had stool on her. The CNA left Resident B sitting in an upright position to go into the bathroom to clean up the roommate. She thought about taking Resident B to the dining room to place her at a table for breakfast, but decided that it wouldn't take long to clean up the roommate. When the CNA finished cleaning up the roommate and opened the bathroom door, she found Resident B on the floor. Resident B was bleeding from her chin and had bruising on her face. The resident was assessed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	by the nurse. Resident B required one person assistance for transfers and required two staff assistance for toileting. She felt Resident B looked okay alone in her wheelchair when she assisted the roommate. 2. The record for Resident J was reviewed on 2/22/24 at 9:52 a.m. The diagnoses included, but were not limited to, dementia, hypertensive urgency, Stage 3 chronic kidney disease, longstanding persistent atrial fibrillation, old myocardial infarction, low back pain, altered mental status, dysuria, weakness, osteoarthritis, repeated falls, and difficulty in walking. The Admission MDS assessment, dated 9/12/23, indicated the resident was severely cognitively impaired. She required substantial to maximum assistance for mobility and ADLs. The nurse's notes, dated 9/13/23 at 8:30 p.m., indicated the resident was found sitting on the floor in front of her wheelchair in her room. She indicated that she was trying to go to the restroom and slid out of her chair onto the floor. She did not hit her head and was not in any pain. No injuries were noted by this nurse. The nurse and CNA assisted the resident off of the floor to a standing position, then sat her back into her wheelchair and helped her to the restroom. The nurse's note, dated 9/22/23 at 11:59 p.m., indicated the resident was found at 10:00 p.m., on the floor, on her bottom, in front of the bedside dresser, beside the left side of her bed with her walker to her left side. The resident had no injuries and indicated that she was walking to her bed and could not reach her walker and did not make it to her bed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The IDT note, dated 9/25/23 at 11:37 a.m., indicated the resident had a fall during the night. The resident indicated she was attempting to get into bed, but her walker was out of reach. The previous interventions were reviewed, and a new intervention was to keep the walker within reach. The nurse's note, dated 10/13/23 at 6:45 p.m., indicated the resident was found sitting on the floor by a CNA at 6:40 p.m. The resident indicated that she was attempting to hang up clothing in the closet cabinet and when she stood up from her wheelchair to do so. When she went to sit back down, the wheelchair moved to one side due to one wheel being locked and the other wheel not being locked. The resident indicated she slid down to the floor in a sitting position. The resident did not hit her head or injure herself in any way. No injuries or symptoms of pain or discomfort were observed by the nurse at this time. The resident was helped up and put into her wheelchair by the CNA and the nurse. The IDT note, dated 10/16/23 at 11:19 a.m., indicated the resident's unwitnessed non injury fall in her room was reviewed. The resident's wheelchair wasn't locked on one side when she went to sit down, and she fell on her buttocks to the floor. The resident did not hit her head or lose consciousness. The root cause of the fall was that the wheelchair was not locked on one side. The resident was severely cognitively impaired. The new fall intervention was to add anti rollbacks to the wheelchair. The nurse's note, dated 10/20/23 at 11:01 a.m., indicated a member of therapy was walking by the resident's room and noticed the resident sitting on the floor with her back against the frame of the door. Her knees were bent and she was facing the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	door. The nurse obtained the resident's vital signs. The resident had not yet had her medication on this day and her blood sugar was elevated. The IDT note, dated 10/20/23 at 12:14 p.m., indicated the resident's non injury unwitnessed fall was reviewed. The resident was in her room ambulating to the restroom when she fell. The resident was severely cognitively impairment. The current fall interventions were reviewed. The new fall intervention was to toilet the resident before and after meals. The nurse's note, dated 10/22/23 at 10:12 p.m., indicated the nurse was walking by the resident's room and noticed the resident on the floor, in front of her wheelchair in the doorway of the bathroom. The resident had no injury. Her old yellow bruises, from previous falls, were observed. The nurse and CNA lifted the resident back into her wheelchair. The nurse educated the resident on using her call light. The IDT note, dated 10/23/23 at 11:38 a.m., indicated the resident's fall was reviewed. The root cause of the fall was because the resident needed to go to the bathroom. The resident was severely cognitively impaired. The current fall interventions were reviewed. The new fall intervention was to provide a touch pad call light. The nurse's note, dated 10/25/23 at 2:58 a.m., indicated the resident was monitored related to her recent fall. Staff monitored the resident frequently related to the wheelchair placement. The resident was often observed sitting on the edge of her wheelchair, chair, or the side of her bed. The resident was also often observed reaching for objects across from her. Staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	encouraged the resident to call for assistance or to be closer to the objects she needed, in place of reaching for them. The nurse's note, dated 10/28/23 at 10:22 p.m., indicated the resident was observed sitting on the floor, beside her bed, with her wheelchair beside her. The resident was sitting upright on her bottom, with her legs stretched out in front of her. The resident denied falling, hitting her head, arms, or legs. The resident indicated she was going to close her blinds but started to fix her blankets on her bed. Her legs gave out and she sat on the floor. Two staff assisted the resident back into her wheelchair. The resident had removed her shoes but had non-skid socks in place to her bilateral feet. The resident indicated her legs felt like pins and needles at times, but no other pain. The IDT note, dated 10/30/23 at 11:20 a.m., indicated the resident's non-injury fall was reviewed. The resident was found on her buttocks on the floor, after she indicated her legs gave out. The root cause of the fall was due to the resident doing things in her room without assistance. The resident was severely cognitively impaired. The new fall intervention was to utilize a "call don't fall" sign in the resident's room. The nurse's note, dated 11/10/23 at 8:15 p.m., indicated the resident was found sitting on the floor in her bathroom between her wheelchair and the toilet. She indicated that she had used the restroom and was attempting to transfer back to the wheelchair, and it rolled out from underneath her, and she slid down to the floor. The nurse and CNA helped the resident up off the floor and back into her wheelchair. The IDT note, dated 11/13/23 at 12:02 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	indicated the resident's fall while transferring herself from the toilet to her wheelchair was reviewed. The wheelchair rolled from underneath her. The root cause of the fall was that the resident toileted herself without assistance. The resident was severely cognitively impaired. The new fall intervention was to toilet the resident before bedtime. The nurse's note, dated 11/13/23 at 8:30 p.m., indicated the resident was found sitting on the floor in her bathroom, between the wheelchair and the toilet. She indicated that she had to use the restroom and was attempting to transfer from the wheelchair to the toilet. She slid out of the wheelchair and down to the floor. The nurse and the CNA helped the resident up off the floor and back into her wheelchair. The IDT note, dated 11/14/23 at 9:32 a.m., indicated the resident's unwitnessed non injury fall on 11/13/23 around 8:30 p.m. was reviewed. The resident was in her bathroom without staff assistance, transferring herself from the commode to the wheelchair, when the fall occurred. The resident was severely cognitively impaired. The new fall intervention was to place a magnetic stop sign across the bathroom door to deter the resident from going into the bathroom unassisted. The nurse's note, dated 11/14/23 at 8:00 p.m., indicated a CNA entered the resident's room and found her sitting on the floor, in the middle of the room, with her wheelchair behind her. The resident indicated she was leaning forward trying to open the dresser drawer to get her pajamas out and she slid out of the wheelchair and onto the floor. The nurse and CNA helped the resident up off the floor and back into the wheelchair. While			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	assessing the resident for injuries, the nurse observed the existing 4-inch by 4-inch bruised area on the right buttock. The resident was reminded to use her call light to alert staff of her need for help. The IDT note, dated 11/15/23 at 11:31 a.m., indicated the resident sustained a minor injury during the unwitnessed fall on 11/14/23 around 8:00 p.m. The resident was in her room attempting to get clothes out of her dresser when she leaned forward to get in her dresser. The resident's bed was prohibiting some space for her to be able to get into her dresser fully. The resident was severely cognitively impaired. The new fall intervention was to move the bed against the wall. The nurse's note, dated 1/23/24 at 6:15 p.m., indicated a meeting with the resident, resident representative, Social Service Director, and the MDS Coordinator. They discussed the resident needing increased assistance with transfers and therapy was to evaluate and pick up three times weekly for physical therapy services. The care plan, dated 1/29/24, indicated the resident was at risk for falling related to decreased mobility and cognitive impairment. The interventions included, but were not limited to, 1/29/24 encourage or assist the resident to assume a standing position slowly, keep the call light within reach, complete a lift evaluation, staff were to assist the resident with transfers as needed, therapy was to evaluate and treat as needed, transfers with a sit-to-stand lift, wheelchair with a cushion for mobility. During an interview on 2/22/24 at 1:50 p.m., LPN 11 indicated on 1/27/24 the resident had a fall. She was assisted to her knees after toileting. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	resident required assistance of one staff member. A lift was now being used. The interventions were to remind her not to go to the bathroom by herself. She could understand being told to let staff assist. The Fall Management Program Guidelines, reviewed 12/31/23, included, but was not limited to, " ... 2 ... This included an investigation of the circumstance surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episodes and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions ... 6. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours. 7. Discuss risks and interventions with resident and/or responsible party and communicate interventions during shift report." Cross Reference with F725. This citation relates to Complaint IN00428620 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	§483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure a resident did not receive a psychotropic medication in an excessive dosage without adequate documentation for its use for 1 of 5 residents reviewed for unnecessary medications. (Resident 30) Finding includes: The record for Resident 30 was reviewed on 2/20/24 at 1:55 p.m. The diagnoses included, but were not limited to, Alzheimer's disease; dementia in other diseases classified elsewhere without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; depression; and psychotic disorder with delusions due to known physiological condition. The Quarterly Minimum Data Set (MDS) assessment, dated 9/28/23, indicated the resident had severe cognitive impairment with frequent trouble sleeping and concentrating and wandered frequently but not daily. No hallucinations or delusion were present. A care plan, dated 8/2/22 with a last review date of	F 0757	F757 Drug Regimen is Free from Unnecessary Drugs 1 Resident 30 had no adverse effects noted due to the alleged deficient practice. Resident 30 had Target Behavior Monitoring orders added for delusions and hallucinations. Resident had a GDR of Zyprexa initiated on 3/8/24. 2 All residents with psychotropic medication ordered have the potential to be affected. All residents who take psychotropic were reviewed to ensure GDR has been attempted per guidelines unless sufficient documentation is in place if a GDR is contraindicated or has failed. Nursing staff were provided education on psychotropic medication use, gradual dose reductions, and documenting behaviors. 3 As a measure of ongoing	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	12/28/23, indicated the resident was at risk for adverse consequences related to receiving antipsychotic medication for psychotic disorder with delusions due to known physiological condition. The interventions included, but were not limited to, administer medications per physician order; attempt Gradual Dose Reduction (GDR) in two separate quarters (with at least one month between attempts) during the first year the resident received the medication, then yearly, unless clinically contraindicated; attempt to give the lowest dose possible; pharmacy consultant review as needed; and review for continued need at least quarterly. The physician's order, dated 2/17/23, indicated the resident was to be monitored three times a day for target behaviors of aggression towards others and being tearful/withdrawn. The physician's order, dated 3/6/23, indicated the resident was to be monitored three times a day for a target behavior of exit-seeking. On 3/3/23, the physician gave an order for the resident to have Zyprexa 7.5 mg (milligrams) to be given at bedtime for psychotic disorder with delusions due to known physiological condition On 9/19/23, a recommendation was given for a Gradual Dose Reduction (GDR) of the Zyprexa from 7.5 mg to 5 mg at bedtime to begin 9/20/23. On 10/3/23, the Psychiatric Nurse Practitioner (NP) visited the resident and indicated the resident had failed the GDR and increased the Zyprexa back to 7.5 mg from 5 mg. She indicated a nurse reported the resident was having periods of agitation and paranoid thinking towards staff and was beating on doors to get out of the memory care unit. The		compliance, the DHS or designee will audit 3 residents on weekly x 1 month, every other week x 2 months, then monthly x 3 months to ensure GDR has been attempted per guidelines or sufficient documentation is in place if a GDR has failed or is contraindicated. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	NP indicated that she felt this should be considered as a failed GDR as he was also slightly irritable compared to last visit. No delusions or hallucinations were observed during this visit. The IDT (Interdisciplinary Team) progress notes, dated between 9/1/23 and 10/31/23, indicated the resident experienced no adverse reactions or visible side effects to the GDR; had no increase in behaviors; continued to be pleasant with staff and others; and enjoyed going outside for the weather. The Medication Administration Records (MAR) Target Behaviors completed by the nursing staff and the Behavior Analysis Reports completed by the CNAs (Certified Nurse Aides) on any behaviors the resident was experiencing, dated between 9/1/23 and 10/31/23, failed to list any type of behaviors by the resident. During an interview with the Director of Nursing (DON) on 2/22/24 at 10:25 a.m., she indicated if the Behavioral Analysis Report had a N/A (not applicable) in the boxes, then the resident did not have any behaviors. During an interview with LPN 13 on 2/22/24 at 1:15 p.m., she indicated the resident was a pretty calm guy, but can be grumpy when people try to talk to him. He had no real behaviors that she saw. During an interview with the DON on 2/22/24 at 2:15 p.m., she indicated she looked through the resident's record to determine why the Psychiatric NP felt the GDR failed. She indicated she spoke with the NP and that although he was not having any behavior issues, he was more irritable on the day she saw him so she increased the Zyprexa back to 7.5 mg and considered the GDR a failure.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility's current policy, titled Psychotropic Medication Usage and Gradual Dose Reduction, included, but was not limited to, "Purpose: To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefits with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team. Procedures: 1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process. 2. Regular monthly review of antipsychotics in CAR (Clinically At Risk) for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of polypharmacologic medications are therapeutic and remain beneficial to the resident. 3. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate. 4. A gradual dose reduction (GDR) will be attempted for two (2) separate quarters (with at least one month between attempts) per the physician's recommendation. Gradual dose reduction must be attempted annually thereafter, unless medically contraindicated..." 3.1-48(b)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner for 5 of 5 observations. This deficient practice had the potential to affect all 79 of 79 residents currently residing at the facility. Findings include: 1. During the initial tour of the kitchen on 2/19/24 between 9:25 a.m. and 10:00 a.m., while in the presence of the Assistant Director of Food Service, the following concerns were observed: - The knife holder next to the stove had a film of moderate dust across the top where the knives entered. - The reach in freezer in the dry storage - inside the door frame at the bottom corner there were large yellow food particles; the bottom shelf of the 3 door unit had a heavy soil of tan and yellow food crumbs and green beans. - The reach-in freezer in the kitchen - the bottom	F 0812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1 No residents were affected by the alleged deficient practice. 2 All residents had the potential to be affected. Kitchen Sanitation education was provided to Food Services staff. The following actions were taken to correct the concerns noted: a Knife holder cleaned b Reach in freezer in the dry storage was cleaned. c Reach in freezer in the kitchen was cleaned. d Reach in freezer and fridge doors were cleaned. e Tilt skillet and surrounding area cleaned. f Stove backsplash cleaned. g Convection oven cleaned.	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	shelf of both sides had a moderate amount of crumbs on it. - Both of the reach in freezers and reach in refrigerator had moderate smears and streaks down the stainless steel doors. - The tilt skillet - both sides, edges and floor on both sides had a heavy grease build up with food particles in it. - The backsplash of the stove had a moderate amount of brown and black splatters. - The right side of the convection oven had a heavy build up of grease and splatters and streaks running down the side with a moderate amount of crumbs around the base. - The shelf under the steam table and around the edges and corners had yellow crumbs and white water spots. - The edges around the inside of the sandwich station had a moderate amount of white and yellow crumbs; the entire outside of the station had heavy streaks which ran down the length of the station. - The wall behind the grill and stove had a light coating of grease on it. - 4 of 4 trash cans had brown and white streaks which ran down the outsides. 2. During the meal service observation on 2/22/24 at 11:30 a.m., the same concerns observed at 9:25 a.m. remained. 3. During a kitchen observation on 2/21/24 at 10:35 a.m., while the Director and Assistant Director of Food Services were working on food prep, the following concerns were observed: - The knife holder next to the stove had a film of moderate dust across the top where the knives entered. - The reach in freezer in the dry storage - inside the door frame at the bottom corner there were		h Shelf under steam table and surrounding area cleaned. i Sandwich station and surrounding area cleaned. j Wall behind the grill and stove cleaned. k Trash cans cleaned. l Floor under condiment shelf cleaned. m Dishwasher and dishwasher side drain cleaned. n Floor under utensil rack cleaned. Utensils and bins washed. o Inside sandwich station cleaned. p Fryer and fryer baskets cleaned. q Stove cleaned. 3 As a measure of ongoing compliance, the DFS or designee will complete kitchen sanitation audits weekly for 1 month, then every other week for 2 months, then monthly for 3 months. 4 As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	large yellow food particles; the bottom shelf of the 3 door unit had a heavy soil of tan and yellow food crumbs and green beans. - The reach-in freezer in the kitchen - the bottom shelf on both sides had a moderate amount of crumbs on it. - Both the reach in freezers an reach in refrigerator had a moderate amount of smears and streaks which ran down the length of the doors. - The tilt skillet - both sides, edges and floor on both sides had a heavy grease build up with food particles. - The backsplash of the stove had splatters of brown and black on it. - The right side of the convection oven had a heavy build up of grease with splatters and streaks running down the side with a moderate amount of crumbs around the base. - The wall behind the grill and stove had a light coating of grease on it. - The shelf under the steam table and around the edges and corners had yellow crumbs and white water spots - The edges around the inside of the sandwich station had a moderate amount of white and yellow crumbs; the entire outside of the station had heavy streaks which ran down it. - 4 of 4 trash cans had brown and white streaks running down the outsides. - Under the condiment shelf by the door to the dining room were 3 sugar and 1 sweet and low packets and a plastic bottle cap on the floor under the shelf. - There was a heavy amount of food particles in the dishwasher side drain and pieces of plastic and paper in the water in the machine. Pans and cooking utensils had just be run through the machine. - There was a scoop on the floor under the rack where the utensil bins were.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	- Inside the sandwich station, a bag of lettuce was open and spilled inside on the shelf. - The fryer had a moderate amount of brown food particles inside the oil and around the inner ledge, 2 fries were in the oil and 1 tator round was on the inside ledge. - There was a heavy coating of brown batter on the fry baskets. - The stove was currently in the process of being repaired as the burner flames were too high. When the edges in front, top and back of the stove in front of the backsplash were removed, the foil underneath the burners was heavily soiled with burnt spills of black and brown in color along with multiple food particles and heavy grease build up. In an interview with the Corporate Executive Director on 2/21/24 at 11:25 a.m., she indicated the Corporate Dietary Manager had noticed the knife holder was not as clean as it should have been. During a random observation of the dishwasher on 2/21/24 at 3:00 p.m., the same pieces of paper and plastic as well as a piece of aluminum foil seen at 10:35 a.m. was still in the machine water. The side drain remained with a heavy accumulation of food particles. A dietary aide was observed running aluminum baking pans, plastic pitcher and aluminum bowls through the machine. 5. During a kitchen observation on 2/22/24 at 2:20 p.m., the following concerns were observed: - The reach in freezer in the dry storage - inside the door frame at the bottom corner there were large yellow food particles; the bottom shelf of the 3 door unit had a heavy soil of tan and yellow food crumbs and green beans. - The reach-in freezer in the kitchen - the bottom shelf on both sides had a moderate amount of crumbs on it.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	- Both of the reach in freezers and reach in refrigerator had a moderate amount of smears and streaks which ran down the length of the doors. - The tilt skillet - both sides, edges and floor on both sides had a heavy grease build up with food particles. - The backsplash of the stove had splatters of brown and black on it. - The right side of the convection oven had a heavy build up of grease with splatters and streaks running down the side with a moderate amount of crumbs around the base. - The wall behind the grill and stove had a light coating of grease on it. - The shelf under the steam table and around the edges and corners had yellow crumbs and white water spots - The edges around the inside of the sandwich station had a moderate amount of white and yellow crumbs; the entire outside of the station had heavy streaks which ran down it. - 4 of 4 trash cans had brown and white streaks running down the outsides. - There was a heavy coating of brown batter on the fry baskets. - There were 3 sweet and low packets, 3 sugar packets and a plastic bottle cap on the floor under the condiment shelf by door to the dining room. During an interview with the Corporate Dietary Manager at this time, she indicated the dish machine was emptied after every meal and then refilled. It was de-scaled weekly. 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure a staff member with COVID-19 and symptoms was isolated and tested prior to working with the residents for 1 of 5 staff observed for infection control. Findings include: During an observation on 2/22/24 at 8:15 a.m. LPN (Licensed Practical Nurse) 4 began to prepare medications for Resident 14. During the	F 0880	F880 Infection Prevention and Control 1 No residents were affected by the alleged deficient practice. 2 All residents had the potential to be affected. Contact tracing was performed to determine if any residents had close exposure to the COVID positive nurse and tested if indicated per the COVID-19 Identification and Management	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	observation, the LPN had audible congestion, was sniffling, and appeared generally unwell. He began to have perspiration during the medication administration of medications to Resident 14. During an interview on 2/22/24 at 8:38 a.m., after completing the medication administration as he drew up insulin for Resident 14, he indicated he had started with sinus pressure on 2/21/24. On 2/22/24, he was a little warm and had body aches. He probably needed to test himself for COVID-19, but had not done so yet. He had not let anyone know he wasn't feeling well. He had just come in and went straight to work. He then went into Resident 14's room and administered her insulin to her. During an observation on 02/22/24 at 8:56 a.m., LPN 4 reported to his Director of Nursing he needed to COVID test himself. The DON provided him with a mask and took him down the Cherry Hill Hall to a treatment cart and provided him with a COVID-19 test and told him to test himself per the manufacturer's guidelines. LPN 4 tested himself, utilizing a COVID-19 self-testing kit. At 9:00 a.m., the test was observed to result positive for COVID-19. He reported the results to his DON and did subsequently leave the facility. The LTC Respiratory Surveillance Line List, indicated the facility had several residents currently positive for COVID-19. The outbreak began on 2/18/24 when a staff member tested positive for COVID-19. Since that time, 1 additional staff member and 4 residents had tested positive. Three of the residents which had tested positive resided on the Harvest Place hallway. The as worked schedule for LPN 4 indicated he had worked on the Harvest Place hallway on		policy. All residents were assessed for COVID symptoms and tested if symptoms were present. No resident had any adverse effects. All staff were interviewed and tested if symptoms present. All staff provided education on COVID-19 Identification and Management Policy. 3 As a measure of ongoing compliance, the DHS or designee interview 3 staff members to ensure no COVID symptoms are present weekly x 1 month, then every other week x2 months, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	February 17, 18, 19, 21, and 22, 2024. During an interview 2/22/24 at 4:23 p.m., the Director of Nursing indicated they would test staff and residents for COVID-19 based on symptoms and would test for any one single symptom. The most current COVID-19 Identification and Management policy included, but was not limited to, "... Testing for COVID-19... Residents and staff, with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test (POC) [point-of-care] for COVID-19 as soon as possible..." 3.1-18(b)(1)			