STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155478	A. BUILDING 00 B. WING	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERS OF JASPER THE	2909 HOWARD DR JASPER, IN 47546

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427390 and IN00422885. Complaint IN00427390: Federal/state defeciencies related to the allegations are cited at F656. Complaint IN00422885: No deficiencies related to the allegations are cited. Survey date: February 6, 2024 Facility number: 000314 Provider number: 155478 AIM number: 100274210 Census bed type: SNF/NF: 66 Total: 66 Census payor type: Medicare: 3 Medicaid: 46 Other: 17 Total: 66 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on February 8, 2024.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 6th, 2024 to the complaint survey completed on February 6th, 2024. We respectfully request that a desk review be considered. The facility will provide additional information as needed to identify compliance.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beau Kellams	Executive Director	02/21/2024

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.

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	the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or			

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	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview, and record review, the facility failed to ensure the plan of care was implemented for 1 of 3 residents reviewed for ADL (activities of daily living) care provided. A resident was not assisted by two staff members during a transfer during incontinence care per the resident's plan of care. (Resident D, Resident C) Finding includes: During an interview on 2/6/24 at 10:35 A.M., Resident D indicated that they had reported CNA 9 for punching her in the stomach while providing care. Resident D indicated that CNA 9 transferred her from her wheelchair to her bed using a Hoyer mechanical lift prior to providing incontinence care. Resident D indicated that CNA 9 slipped and accidentally hit her stomach while providing care. During record review on 2/6/24 at 11:30 A.M., Resident D's diagnoses included, but were not limited to unspecified multiple injuries, person injured in unspecified motor vehicle accident, chronic pain, displaced commuted fracture of right patella, fracture of sternum, fracture of unspecified forearm, and fracture of right lower leg. Resident D's most recent Admission MDS (Minimum Data Set) dated 12/23/23, indicated the resident's cognition was moderately impaired, had upper extremity impairments to both sides, had lower extremity impairments to 1 side, required substantial to maximum assistance to roll left and right, and was dependent with form bed to chair.	F 0656	**F656 Comprehensive Care Plans** What corrective action will be accomplished? All nursing staff members will be in-serviced on mechanical lift use and the requirement of 2 staff members needed for mechanical lifts. All residents ADL care plans will be reviewed. Resident D care plan and profile was updated to indicate resident is assist of 2 staff during transfers. Resident C care plan and profile were reviewed for ADL care by the DNS/Designee. How will you identify other residents? All residents have the potential to be affected by the alleged deficient practices. All residents care plans will be reviewed. DNS/Designee to ensure resident care plans are accurate for ASL care/Transfers. What measures will be put into place? All nursing staff members will be in-serviced on mechanical lift use and the requirement of 2 staff members needed for	03/06/2024

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	Resident D's physician orders included, but were not limited to; activity level: up as needed with two person assist (started 12/17/23). Resident D's care plan included, but was not limited to; Resident requires assistance with ADLs including bed mobility, transfers, eating and toileting related to: impaired mobility, recent motor vehicle accident, with multiple fractures, pain. An intervention included, two assist with transfers (started 12/18/23). During a review of facility reported incidents on 2/6/24 at 11:00 A.M., a facility reported incident dated 1/30/24 included that Resident D told Resident C that CNA 9 hit her in the stomach. During a review of the facility's investigation into the allegation involving an incident between Resident D and CNA 9, a typed statement signed by Resident C and dated 1/30/24, included, "[CNA 9] was observed by [Resident C] using the Hoyer on room mate [Resident D] alone..." A written interview between the facility administrator and DON (director of Nursing) and CNA 9, signed and dated 1/30/24, included, "... [CNA 9] stated he used the Hoyer to transfer [Resident D] form (wheelchair) to bed. He stated she was wet (and) he changed her in bed.... During an interview on 2/6/24 at 1:45 P.M. LPN 8 indicated she was Resident D's nurse the date of 1/30/24 when an allegation of abuse was made against CNA 9. LPN 8 indicated she was unaware of any other staff members being in Resident D's room while CNA 9 provided care and was accused of hitting Resident D. During an interview on 2/6/24 at 1:50 P.M., CNA 3		mechanical lifts. All new residents will be assessed by IDT after admission to determine ADL care plan or after a resident experiences a significant change. How corrective measures will be monitored: To ensure compliance, the Director of Nursing/designee is responsible for the completion of the Mechanical Lift Transfer QAPI tool weekly times x4, monthly x 6 and then quarterly x2, until continued compliance is maintained for 3 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. .	

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	indicated that if a resident is care planned for assistance of 2, staff should find a second staff member to assist during care. CNA 3 indicated that there should always be 2 staff members present when transferring a resident with a Hoyer mechanical lift. On 2/6/24 at 2:25 P.M., the DON supplied a skills validation sheet titled, Mechanical Lift, dated 3/2012. The validation sheet included, "Two (2) staff is required at all times when using a mechanical lift." This citation relates to complaint IN00427390. 3.1-35(g)(2)			