STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 00 B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00440513 and IN00440297. Complaint IN00440513 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00440297 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: August 13 and 14, 2024 Facility number: 004268 Provider number: 155735 AIM number: 200504460 Census Bed Type: SNF/NF: 36 SNF: 17 Residential: 32 Total: 85 Census Payor Type: Medicare: 15 Medicaid: 29 Other: 9 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 22, 2024.	F 0000	The submission of this Plan of Correction does not indicate an admission by Ashford Place Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Ashford Place Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for Ashford Place Health Campus for our complaint survey completed on 8/14/24. We initiated immediate interventions when concerns were identified on this date. We respectfully request desk review with paper compliance for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at 317-398-8422. Sincerely, Zach Simpson Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure interventions to prevent falls were effectively implemented when Resident C exhibited signs and symptoms of lethargy, drowsiness, and sedation and failed to ensure staff used a gait belt during the transfer of a Resident D who required more than limited assistance with transfers for 2 of 3 residents reviewed for falls. This deficient practice resulted in Resident C falling in the shower and sustaining fractures to the left shoulder blade, the left second rib, and the endplate of the third lumbar spinal disc. (Resident C and Resident D) Findings include: 1. The clinical record for Resident C was reviewed on 8/14/24 at 8:30 a.m. The diagnoses included, but were not limited to, dementia, osteoporosis, and insomnia. A quarterly Minimum Data Set (MDS) assessment, dated 5/2/24, indicated Resident C was cognitively impaired. The resident's functional status was dependent of the staff person to provide all the effort for the resident to bathe. The staff was to provide more than half of the effort to assist with transferring in and out of shower. The resident did receive antidepressants and had a history of falling. A care plan, dated 1/16/24, indicated, "Resident has impairment in functional status r/t [related to] decreased mobility, weakness, and other comorbidities..."	F 0689	1 Resident C was affected by alleged deficient practice. Resident C's medication was adjusted to help with lethargy/sleepiness. Resident care plan updated to utilize shower chair instead of shower bench. 2 All residents who utilize the shower bench have the potential to be affected by alleged deficient practice. Director of Health Services and/or Designee completed Health Care Center audit of like residents. Nursing staff in-serviced on utilizing shower bench safely. 3 As a measure of ongoing compliance, the Director of Health Services and/or Designee will complete an audit of like residents who utilize shower bench and ensure its able to be used safely, 3 times weekly x 4 weeks, twice weekly x 8 weeks, and then once weekly x 3 months. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until	09/06/2024

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	A physician order, dated 3/22/24, indicated staff was to monitor Resident C for signs of adverse effects with the usage of "hypnotic/sedative/tranquilizer medication." A care plan for fall risk, dated 6/3/24, indicated staff should review the use of a sleep aid medication, change the administration time of a sleep aid medication, encourage activities in common area prior to breakfast, check the resident every two hours during the night shift, encourage resident to sleep in bed at night, use a silent bed alarm on the bed and the recliner, keep wheelchair out of site (sic), offer to get up at 4:00 a.m., utilize a fall mat, utilize a low bed, and staff should assist with transfers as needed. A psychiatric visit note, dated 6/28/24, indicated, "The patient's trazodone was reduced per pharmacy recommendation and she has had significant difficulty with sleeping. We are going to increase trazodone from 75 milligrams to 150 milligrams at HS [night]..." A physician order, dated 6/28/24, indicated Resident C was to receive 150 milligrams (mg) of trazodone (antidepressant medication) at night for insomnia. The antidepressant was used as a hypnotic medication. The medication was discontinued on 7/27/24. A psychiatric visit note, dated 7/26/24, indicated resident continued to have problems with sleeping. The plan was to increase current trazodone medication dosage from 150 milligrams to 200 milligrams. A physician order, dated 7/27/24, indicated Resident C was to receive 200 mg of trazodone at night. The medication was discontinued on		100% compliance is maintained. 1 Resident D was affected by alleged deficient practice. Resident D's care plan was updated to utilize gait belt with transfers. 2 All residents who transfer with the assistance of one have the potential to be affected by alleged deficient practice. Director of Health Services and\or Designee completed Health Care Center audit of like residents. 3 As a measure of ongoing compliance, the Director of Health Services and/or Designee will complete an audit of like residents and audit 3 resident transfers to ensure correct plan of care for transfers is followed, 3 times weekly x 4 weeks, twice weekly x 8 weeks, and then once weekly x 3 months 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	7/31/24. The July 2024 Medication Administration Record (MAR) indicated the resident was showing signs and symptoms of side effects with the usage of hypnotic/sedative/tranquilizer medication on the following day and shift: 7/31/24 - evening shift - drowsiness. A nursing note written by Director of Nursing (DON), dated 7/31/24 at 1:43 p.m., indicated the resident was more lethargic, had difficulty staying awake during meals, and the psychiatric care provider was notified. A nursing note, dated 8/1/24 at 6:19 a.m., indicated "Psych [psychiatric] services gave ok to reduce Trazodone down to previous dose..." A physician order, dated 8/1/24, indicated Resident C was to receive 150 mg of trazodone at bedtime. The August 2024 MAR indicated the following days and shifts the resident was showing signs and symptoms of side effects with the usage of hypnotic/sedative/tranquilizer medication: 8/2/24 - evening shift - extreme drowsiness, 8/3/24 - evening shift - drowsiness, 8/4/24 - day shift - drowsiness and evening shift - sedation. Resident C's clinical record reviewed on 8/14/24, did not include additional safety interventions initiated to address the resident's change of condition. A nursing note, dated 8/4/24 at 1:54 p.m., indicated "[Resident C's Representative] in to visit		IDR request Dear Brenda, On behalf of Trilogy Health Services at Ashford Place Health Campus and in accordance with Administrative 42 CFR 488.331, we respectfully request an Informal Dispute Resolution for F689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2). We at Trilogy Health Services note Ashford Place Health Campus was in substantial compliance per the CMS definition by 8/8/24. We request the evidence provided during the abbreviated survey and within this informal dispute resolution be reviewed as an irrefutably indicates the CMS criteria for past noncompliance was achieved prior to the start of the survey. **Exhibit A: (CMS State Operations Manual 7510.1 – Determining Citations of Past Noncompliance at the Time of the Current Survey. Pg 116.)** *"Past noncompliance may be identified during any survey. For the purpose of making determinations of current noncompliance or past noncompliance, the survey team is expected to follow the*	

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	resident, states she has noticed resident is sleeping a lot more lately and would like trazodone held this eve [evening]." A nursing note, dated 8/4/24 at 3:13 p.m., indicated, "Resident fell in shower while being assisted with shower by nursing assistant..." A care plan for fall risk, revision date 8/5/24, indicated the resident was to utilize a shower chair during showers. A nursing note by DON, dated 8/6/24, indicated, "IDT [Interdisciplinary team] note: Resident has been more lethargic, [Psych Provider 13] increased Trazodone on 7/26. Since reached out to [Psych Provider 13] to let her know that resident was sleeping all day and not tolerating increased dose. Dose was reduced back down to previous dose. Resident continues to be very lethargic and requiring increased assistance with transfers and mobility. Resident had a fall on 8/4, slipped off bench in shower...IDT recommend staff to use shower chair when giving resident a shower. [Resident C Representative] has requested Trazodone be held on 8/4 and 8/5 due to lethargy and not waking to eat meals. Improvement noted in alertness, continues to have difficulty staying awake for long periods of time. Resident did get up and go down for breakfast this morning. Sent email to [Psych Provider 13] to address concerns with Trazodone..." A nursing note, dated 8/6/24, indicated, "Res [resident] had x-ray done to left arm with results showing a fx [fracture] to left scapula NP [Nurse Practitioner] here and made nursing aware of results. Res cries out in pain when moving res from recliner to w/c [wheelchair] or when touching area of back shoulder. Res sleeps most of the day		*investigative protocols and surveyor guidance.* *To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:"* *1 The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific tag) at the time the situation occurred;* *2 The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and* *3 There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific tag.* To reiterate, Ashford Place Health Campus was **in compliance** at the time of the survey entrance. I will clarify below how the campus met the above noted CMS requirements of Past Noncompliance. Requirements for Past Non-Compliance: *1 The facility was not in*	

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	but is easy to arouse...Writer talked with [representative] and thought sending her out to the ER [emergency room] would be best. Facility transported res via w/c, report called to [name of hospital] ER..." An Episodic Event Report for Resident C, completed on 8/8/24, was provided by the Executive Director on 8/13/24 at 9:59 a.m. It indicated, the date of event 8/4/24, "Resident slid off shower bench. Fractures to left scapula [shoulder blade], left 2nd rib fracture, L3 [third lumbar spinal disc] endplate fracture [tearing of the cartilage and bone on the top and bottom of each disc in back]..." A nursing progress note, dated 8/11/24, indicated, "Resident returned to facility from hospital on 8/9/24..." A statement by Certified Resident Care Assistant (CRCA) 6, dated 8/5/24, indicated the following, "...I was taking her to the shower and placed her on the shower bench. I went to warm up the water and had it spraying in the corner. While she was sitting there with the water running, she started to lean or slide off the bench and I attempted to keep her from falling. But she continued to fall to her side..." An interview was conducted with the Occupational Program Director on 8/14/24 at 10:39 a.m. She indicated Resident C was a single staff person transfer. The staff utilizing a shower bench or shower chair was fine. The resident could tolerate either one. Prior to the resident fall, it was safe to place her on the shower bench. An interview was conducted with CRCA 6 on 8/14/24 at 1:37 p.m. She indicated, on 8/4/24,		*compliance with the specific regulatory requirement(s) (as referenced by the specific tag) at the time the situation occurred;* According to the 2567, “Based on interview and record review, the facility failed to ensure interventions to prevent falls were effectively implemented when Resident C exhibited signs and symptoms of lethargy, drowsiness, and sedation and failed to ensure staff used a gait belt during the transfer of Resident D who required more than limited assistance with transfers for 2 of 3 residents reviewed for falls. The deficient practice resulting in Resident C falling in the shower and sustaining fracture to the left shoulder blade, the left second rib, and the endplate of the third lumbar spinal disc.” Facility’s Response: Resident C: ·Resident C medical record had numerous documentation entries from the perspective nurses regarding difficulty sleeping during the night. Several notifications were made to the primary care physician and attempts to adjust the Trazodone to relieve the resident’s insomnia. These dates include: 5/15/24 Trazodone 50 mg started, 5/17/24 Trazodone increased to 100 mg, 6/1/24	

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	Resident C was not drowsy or lethargic that day. CRCA 6 often placed the resident on the shower bench during showers. The resident was able to tolerate sitting on the bench on previous shower days, so she continued to sit the resident on the bench during bathing. She does get report from previous shifts of the condition of the residents for example: when the resident was last toileted and if they are out of the building. "Trazodone" medication at MedlinePlus drug information at website www.medlineplus.gov, dated 1/15/22, was retrieved on 8/19/24. The website indicated the following, "...Trazodone is used to treat depression. Trazodone is in a class of medications called serotonin modulators. It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance...Trazodone is also sometimes used to treat insomnia...Trazodone may cause side effects...weakness or tiredness...dizziness or lightheadedness...." 2. The clinical record for Resident D was reviewed on 8/14/24 at 9:20 a.m. The diagnoses included, but were not limited to, stroke and muscle weakness. An annual MDS assessment, dated 7/24/24, indicated Resident D was cognitively intact. The resident's functional status was dependent of the staff person to provide all the effort for the resident to go from a sitting position to a stand position. The staff person was to assist over half of the effort when a resident needed to be transferred from a chair to wheelchair. The risk of falling care plan, dated 9/28/21, indicated, "Resident is at risk for falling r/t [related to]: dx [diagnosis] of acute encephalopathy [brain		Trazodone increased to 125 mg, Trazodone decreased to 75 mg, Trazodone increased to 150 mg, Trazodone increased to 200 mg, and 8/1/24 Trazodone decreased to 150 mg. ·During record review it was identified that Resident C had been taking the Trazodone 150 mg since 6/28/24 and tolerating well, then on 7/29/24, Resident C received a new order for Benadryl 25 mg per daughter's request due to Resident C having a rash. Resident received the Benadryl on 7/29/24. Resident C drowsiness clinically appears to have begun after receiving the Benadryl dose. Benadryl was discontinued on 8/12/24. ·According to the 2567 and Resident C care plan the following was implemented and in place: "A care plan for fall risk, dated 6/3/24, indicated staff should reviewed the use of sleep aid medication, change the administration time of a sleep aid medications, encourage activities in common area prior to breakfast, check the resident every two hours during the night shift, encourage resident to sleep in bed a night, use a silent bed alarm on the bed and the recliner, keep wheelchair out of site, offer to get u at 4:00 a.m., utilize a fall mat, utilize a low bed, and staff should assist with transfers as needed." ·All the above care plan	

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	disease], CVA [stroke], weakness, decreased mobility, medication regimen, requires assistance with transfers, incontinent status, pain, and other comorbidities...Encourage resident to assume standing position slowly, Ensure the floor is free of liquids and foreign objects, Keep call light in reach, Encourage to assume standing position slowly, Keep personal items and frequently used items within reach, Provide non-skid footwear..." A nursing note written by Registered Nurse (RN) 5, dated 7/26/24, indicated, "Res [resident] was being transferred to recliner and was dropped. No sign of injury..." A nursing note written by the DON, dated 8/2/24, indicated, "...fall on 7/26, staff was assisting resident from recliner to w/c [wheelchair] to go to the bathroom when the CRCA [Certified Resident Care Assistant 6] had difficulty with transfer causing resident to fall. No injuries noted. Resident just startled from fall. IDT [Interdisciplinary team] recommends gait belt with transfers. Resident remains an assist of 1 [one] with [Activities of Daily Living] ADL's and transfers. Able to make needs and wants known. Resident able to ambulate short distance with walker and uses w/c for long distance..." An event report, dated 7/26/24, indicated Resident D had a witnessed fall in her room while ambulating with assistance. The resident "requires assistance to transfer." The risk of falling care plan, with a revision date 8/6/24, indicated a new intervention, start date of 7/31/24, for the staff to utilize a gait belt when transferring the resident. A typed statement for CRCA 6, dated 7/26/24,		interventions were implemented with emphasis on reviewing the use of the sleep aid medication as evidence by several attempts to adjust the Trazodone to achieve a therapeutic dose. According to the 2567, "Resident C's clinical record reviewed on 8/14/24, did not include additional safety interventions initiated to address the resident change of condition." As mentioned above, several attempts were made to adjust the Trazodone to achieve a therapeutic dose. An additional safety intervention was initiated on 8/5/24 to address the resident change of condition by adding the use of a shower chair during showers. According to the 2567, "An interview was conducted with the Occupational Program Director on 8/14/24 at 10:39 a.m. She indicated Resident C was a single staff person transfer. The staff utilizing a shower bench or shower chair was fine. The resident could tolerate either one. Prior to the resident's fall, it was safe to place her on the shower bench. An interview was conducted with CRCA 6 on 8/14/24 at 1:37 p.m. She indicated, on 8/4/24, Resident C was not drowsy or lethargic that day. CRCA 6 often placed the resident on the shower bench during showers. The resident was able to tolerate sitting on the	

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	indicated the following, "Resident [D] needed to use the restroom, so I went to help her transfer. Resident was in her recliner, and I went to assist her into her wheelchair. During the transfer the resident was unsteady, so I lowered her to the floor..." An interview was conducted with Physical Therapist 3 and Occupational Program Director on 8/14/24 at 10:32 a.m. They indicated they recommend staff to utilize gait belts for all resident transfers. An interview was conducted with CRCA 4 on 8/14/24 at 11:59 a.m. She indicated gait belts were to be utilized to assist with resident transfers. An interview was conducted with Resident D on 8/14/24 at 1:25 p.m. She indicated she had fallen. She stood up from her recliner to be transferred to her wheelchair. The staff person was "too little to transfer me," and lowered her to the floor. She was not hurt. An interview was conducted with RN 6 on 8/14/24 at 1:50 p.m. She indicated she would "assume" that staff should use gait belts to transfer residents. An interview was conducted with CRCA 6 on 8/14/24 at 1:37 p.m. She indicated she was the staff person that was assisting Resident D with a transfer, on 7/26/24, when she had fallen. She did not utilize a gait belt to assist while transferring the resident at the time of the fall. Staff are required to use gait belts for some residents, but not all. An interview was conducted with the DON on 8/14/24 at 1:55 p.m. She indicated it was optional		bench on previous shower days, so she continued to sit the resident on the bench during bathing." Resident D: According to the 2567, "The risk of falling care plan, dated 9/28/21, indicated, "Resident is at risk for falling r/t [related to]: dx [diagnosis] of acute encephalopathy [brain disease], CVA [stroke], weakness, decreased mobility, medication regimen, requires assistance with transfers, incontinent status, pain, and other comorbidities...Encourage resident to assume standing position slowly, Ensure the floor is free of liquids and foreign objects, Keep call light in reach, Encourage to assume standing position slowly, Keep personal items and frequently used items within reach, Provide non-skid footwear..." An Interdisciplinary Team note was written by the DON, dated 8/2/24 with recommendations to initiated gate belt use with transfers. This was updated on the fall care plan. Upon further review of our Policies and Procedures on Guidelines for Gait Belt Use, it states, "Gait belts should be used according to the plan of care for the individual resident. Therefore, at the time Resident D's fall, the	

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	for staff to utilize gait belts to assist with transferring a resident unless the resident was care planned for gait belt use. A fall management program guidelines policy, revised 5/31/17, was provided by the Executive Director (ED) on 8/13/24 at 9:30 a.m. The policy indicated, "...PURPOSE...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...intensive efforts will be directed toward minimizing or preventing injury...PROCEDURES...b. Care plan interventions should be implemented that address the resident's risk factors...2...This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possibly contributing factors, interventions to reduce the risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions...5. The resident care plan should be updated to reflect any new or change in interventions...." A gait belt policy was provided by the Executive Director on 8/14/24 at 1:20 p.m. The policy indicated, "...Purpose...To ensure safety for the resident and staff during transfers and mobility activities. Procedures... 1. Gait belts should be used according to the plan of care for the individual resident. 2. If resident requires use of gait belt, add to resident plan of care that will be communicated to the caregiver. 3. If a resident requires more than limited assists and does not require a lift a gait belt may be used with transfers. 4. An individual campus may designate a gait belt be used during all mobility activities. 5. Gait belts will be provided by the campus and should remain in the campus at all times for use by all staff during transfers. 6. Campus should have various		residents plan of care was being followed and additional interventions were implemented post fall on 7/31/24, to add gait belt with transfers. *2 The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and* Ashford Place Health Campus annual survey was completed on 5/1/24 Event ID V1UT12. The evidence of this standard/recertification survey is in the Indiana State Department of Health Gateway system. The event referenced in this IDR Event ID NQ0C11 with an exit date of 8/14/24 is after the last standard survey entrance on 5/1/24. *3 There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific tag.* Ashford Place Health Campus initiated an immediate plan of correction with sufficient education and auditing to ensure compliance with F689 by utilizing Trilogy Health Services policy and	

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	155735	A. BUILDING 00 B. WING	08/14/2024

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	sizes of gait belts available. 7. Failure to use a gait belt as defined in the resident plan of care or as designated by campus protocol may lead to disciplinary action up to and including termination." The Indiana State Department of Health Nurse Aide Curriculum, revised November 19, 2015, indicated the following, "...PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION...3. Place belt around resident's waist with the buckle in front and adjust to a snug fit ensuring that you can get your hands under the belt...4. Assist the resident to stand on count of three...6. Stand to side and slightly behind resident while continuing to hold onto belt...PROCEDURE #26: TRANSFER TO WHEELCHAIR...2. Place wheelchair on resident's unaffected side...4. Stand in front of resident and apply gait belt around the resident's abdomen..." This citation is related to Complaints IN00440513 and IN00440297. 3.1-45(a)(1) 3.1-45(a)(2)		procedures referencing our Fall Management Program Guidelines with emphasis on shower safety, to put our campus back into substantial compliance prior to the time of survey entrance on 8/13/24. The immediate plan of correction contained the following executed actions: On 8/4/24, The Director of Health Services immediately initiated the Trilogy's policy on Fall Management Program Guidelines with emphasis on shower safety. On 8/7/24, The Director of Health Services and Minimum data set coordinator (MDSC) completed a one-time audit of all other like residents' recent falls comparing to fall care plans to ensure care plans were appropriately implemented with no findings. An Ad Hoc Quality Assurance meeting was held on 8/8/24 with the following, Medical Director, Executive Director, Director of Health Services regarding recent incident from 8/4/24 of Resident C sustaining a fall related injury and to ensure Trilogy's Fall Management Program Guidelines with emphasis on shower safety was followed. Starting on 8/8/24, as part of the	

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			facility's ongoing quality improvement plan the Director of Health Services or designee will audit showers to ensure shower safety interventions are being followed, three times per week for four weeks then, weekly for two months, then monthly for three months until 100% compliance is achieved. In thorough review of our policies, procedures, and guidelines, the leadership team utilized these to guide them through the adverse event. The campus was not deficient in their workflow or process in ensuring the campus met the guideline ensure interventions were effectively implemented to prevent falls. Furthermore, throughout the duration of the abbreviated survey the surveyors noted no deficiencies or evidence of continued noncompliance. The surveyors observed staff members transferring residents appropriately according to their plan of care and with no noted deficiencies or evidence of continued noncompliance. All observations, interviews, medical records reviews, and action plan reviews confirmed the facility's state of substantial compliance. "Past noncompliance (PNC) refers to situations where the facility has taken sufficient corrective actions prior to the survey to both remove	

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			the immediate jeopardy and fully correct the noncompliance before the start of the survey." By end of day on 8/8/24, the campus had taken more than sufficient corrective actions (prior to the survey) to fully correct the noncompliance. An immediate investigation was completed, and all staff were re-educated on Trilogy Health Services policy and procedures on Fall Management Program Guidelines with emphasis on shower safety. In conclusion, of the IDR for citation F689, Trilogy Health Services, and Ashford Place Health Campus IDT, feel that there is substantial evidence and documentation supporting the facilities compliance with F689. The citation received reflecting ongoing non-compliance with F689 is erroneous and should be noted as "Past noncompliance" per the State Operations Manual. Should you have any questions regarding this Request for Informal Dispute Resolution and/or once you have reached a decision regarding it, please contact the undersigned at (765) 376-9646 We are certain that you can appreciate the facility's concerns regarding the surveyors' findings, and we appreciate your careful consideration of this request. Respectfully submitted, Zachary Simpson, Executive	

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			Director Ashford Place Health Campus	