f ′				(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 CO B. WING 09			
		155593	B. WING		09/20/2024		
NAME OF P	ROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD			
COMPAS	SS PARK		800 FREEMASON PARKWAY FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
F 0000							
Bldg. 00							
Diag. 00	This visit was for a	Recertification and State	F 0000	Indiana Masonic Home Cred	ible		
	Licensure Survey.			Allegation of Compliance			
	•			The submission of this plan	of		
	Survey dates: Sept	ember 16, 17, 18, 19, and 20,	1	correction does not indicate			
	2024		1	admission by the Indiana Ma	sonic		
			1	Home, Inc (the "facility") that	the		
	Facility number: 0		1	findings and allegation conta	ined		
	Provider number:	155593		herein are an accurate and t	rue		
	AIM number: 2000	990430		representation of the quality	I		
	Census Bed Type: SNF/NF: 145			care and services provided t	o the		
				residents of the Indiana Mas			
				Home, Inc. This facility recog			
	SNF: 2			its obligation to provide legal	-		
	Total: 147			medically necessary care an services to its residents in ar			
	Census Payor Type	e:		economic and efficient mann	er.		
	Medicare: 9			The facility hereby maintains			
	Medicaid: 84			in substantial compliance wit			
	Other: 54			requirements of participation	for		
	Total: 147			comprehensive health care			
		d d a Didi		facilities. To this end, the pla	n of		
		reflect State Findings cited in		correction shall serve as the			
	accordance with 4	10 IAC 16.2-3.1.		credible allegation of complia	ance		
	01:4	- 1-4-1 C- 14-11 - 124 2024		with all State and Federal			
	Quality review cor	npleted September 24, 2024.		requirements governing the	4 :-		
				management of this facility. I			
				thus submitted as a matter o	1		
				stature only.			
F 0623	483.15(c)(3)-(6)(8	3)	1				
SS=D	Notice Requirem		1				
Bldg. 00	Transfer/Discharg		1				
		•	F 0623		10/18/2024		
	Based on interview and record review, the facility failed to ensure that written notification was		1 0020	1 1. The resident	10/10/2021		
			1	representative of resident 12	3 was		
	provided to the res	ident, the resident's		provided a written copy of the			
	_	to the Office of the State		Notice of Transfer/Discharge	I		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 10/11/2024

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

continued program participation.

Marissa Meahl

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

RN Director of Nursing

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155593	B. W	ING		09/20/	2024
		<u> </u>		CERT TOTAL	I DDD FOO CHEV OF THE TIME OF		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
0014546	20 54514				EEMASON PARKWAY		
COMPAS	SS PARK			FRANK	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Long-Term Care O	mbudsman for 3 of 5 residents			the transfer initiated on 8/11/2	4. A	
	reviewed for writter	n transfer and discharge			written copy of the Notice of		
	notification. (Resid	dent 140, Resident 1, Resident			Transfer/Discharge for the trai	nsfer	
	123)				initiated on 8/11/24 was also		
					provided to the Ombudsman.		
	Findings include:				Resident 123 has moderate		
					cognitive impairment; therefor	e, a	
	1. On 9/18/24 at 2:12 p.m., Resident 140's clinical				written copy was only provided	-	
	record was reviewed. The diagnoses included,				the resident representative an		
		d to, COPD (Chronic			Ombudsman. The resident		
		nary Disease), chronic			representative of resident 1 w	as	
		and orthostatic hypotension			provided a written copy of the		
		pressure that happens when			Notice of Transfer/Discharge f	or	
	standing after sittin				the transfers initiated on 4/25/		
		, , ,			3/14/24, and 3/6/24. A written	,	
	Resident 140's face	sheet had identified a family			copy of the Notice of		
		rgency contact person.			Transfer/Discharge for the		
					transfers initiated on 4/25/24,		
	A progress note, da	ted 7/4/24 at 2:19 p.m.,			3/14/24, and 3/6/24 was also		
		140 was transferred to the			provided to the Ombudsman.		
	hospital emergency	department. The transfer was			Resident 1 has moderate cog	nitive	
	a facility-initiated to				impairment; therefore, a writte		
					copy was only provided to the		
	The clinical record	lacked documentation that the			resident representative and th		
	written notification	of the Notice of Transfer or			Ombudsman. Resident 140 w		
	Discharge documer	nt was provided to Resident			discharged from the facility on		
	_	contact, and the Office of the			7/4/24 and passed away at the		
		are Ombudsman for the			hospital on 7/13/24. Written		
	hospital transfer on				notices were provided to the		
	•				resident and resident		
	2. On 9/19/24 at 10	:00 a.m., Resident 1's clinical			representative for the transfer		
		d. The diagnoses included,			initiated on 7/4/24 at the time		
		d to, diabetes, acute and			the transfer. Written notificatio		
		failure, and heart failure.			the transfer for resident 1 for t		
		,			transfer initiated on 7/4/24 was		
	Resident 1's face sh	neet had identified a family			provided to the Ombudsman.		
		rdian and emergency contact			Progress notes have been ent	ered	
	person.	- 			for each of the above notificat		
	F 2200				in the medical records for	.0110	
	A progress note. da	ted 4/25/24 at 10:10 a.m.,			residents 123, 1, and 140.		

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155593	B. WIN	NG		09/20/	/2024
	NO. 1 TO 1	_	'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			EEMASON PARKWAY		
COMPAS	SS PARK			FRANK	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		1's emergency contact			2 2. All facility residents w		
	_	nt 1 from the facility to the			transfer-discharge episode ha		
		department. The transfer was			the potential to be affected. A	n	
	a facility-initiated t	ransfer.			audit of the past 30 days of		
		10/10/01 10 70			transfer/discharges was		
		ated 3/13/24 at 2:59 p.m.,			completed and all appropriate)	
		1 was scheduled to be			notifications were made and		
		ospital on 3/14/24 and was to			documented in each resident	S	
		hospital. The transfer was a			progress notes.		
	facility-initiated tra	insier.			3 3. The Social Services		
	A progress note. da	ated 3/6/24 at 2:44 p.m.,			Director will continue tracking		
		1 was transferred to the			transfer/discharges with the		
		department on 3/6/24. The			"Notice of Transfer/Discharge	Loa"	
		ity-initiated transfer.			(See attachment A). The log l	•	
					been updated to include		
	The clinical record	lacked documentation that the			documentation of written		
	written notification	of the Notice of Transfer or			notification of transfer/dischar	ge to	
		nts were provided to Resident			the resident, resident	_	
	_	ontact, and the Office of the			representative, and the		
		Care Ombudsman for the			Ombudsman. A new progress	3	
	hospital transfers o	n 4/25/24, 3/14/24, and 3/6/24.			note template has been creat		
					for social services to docume		
	3. On 9/19/24 at 8:	32 a.m., Resident 123's clinical			written notification of		
		ed. The diagnoses included,			transfer/discharge to the resid	lent,	
		d to, cirrhosis of the liver,			resident representative and		
	anxiety, schizoid po	ersonality disorder, and			Ombudsman and will be used	l to	
	dementia.				document notifications for ea	ch	
					facility-initiated transfer. An a		
		sheet had identified an			titled "Notice of Transfer/Disc	harge	
	emergency contact	person.			and Bed Hold Audit" (See		
					attachment B) has been		
		ated 8/11/24 at 9:24 p.m.,			implemented and will be		
		123 was transferred to the			completed for each new		
		department. The transfer was			facility-initiated transfer/disch	-	
	a facility-initiated t	ranster.			The audit will be completed b	-	
					Director of Nursing or designe	ee.	
		lacked documentation that the			4 4. The "Notice of		
		of the Notice of Transfer or			Transfer/Discharge Audit" will		
	 Discharge document 	nt was provided to Resident	1		completed for each facility-ini	tiated	I

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155593	B. W	ING		09/20/	/2024
NAME OF P	ROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP COD		
		·			EEMASON PARKWAY		
COMPAS	SS PARK			FRANK	(LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		contact, and the Office of the			transfer/discharge. Results of		
	_	are Ombudsman for the		audit will be reviewed in the facility		icility	
	hospital transfer on	8/11/24.			Quality Assurance and		
	During on intervious	v on 9/19/24 at 1:54 p.m., Social			Performance Improvement		
	_	the facility had not provided			meetings for the next 6 month	S.	
		of the Notice of Transfer or					
Discharge documents to the residents, their corresponding emergency contact persons, and to the Office of the State Long-Term Care							
	Ombudsman.						
	On 9/19/24 at 10:21	a.m., the Social Services 4					
	provided a copy of	the Compass Park Medical or					
	_	Policy, dated 6/6/2007, and					
		current policy in use by the					
	-	of the policy indicated, "it is					
		impusresidents [leaving					
		rmedical reasonsin					
	accordance with Fe	deral and State guidelines"					
	3.1-12(a)(6)(A)(i)						
	3.1-12(a)(6)(A)(iii)						
F 0625	483.15(d)(1)(2)						
SS=D	Notice of Bed Hole	d Policy Before/Upon Trnsfr					
Bldg. 00	D 1 '4 '	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-	< 0. T			10/10/2024
		and record review, the facility ritten bed hold notification	F 0	525	1 1. The resident		10/18/2024
		resident and to the resident's			representative of resident 123		
	-	of 5 residents reviewed for			provided a written copy of the facility Bed Hold Policy for the		
		ns. (Resident 1, Resident 123,			transfer initiated on 8/11/24.		
	and Resident 140)	ns. (resident 1, resident 123,			Resident 123 has moderate		
					cognitive impairment; therefor	e. a	
	Findings include:				written copy was only provide		
					the resident representative. The		
	1. On 9/16/24 at 10	:55 a.m., Resident 1's clinical			resident representative of resi		
	record was reviewe	d. The diagnoses included, but			1 was provided a written copy		
	were not limited to,	diabetes, acute and chronic			the Bed Hold Policy for the		
	respiratory failure,	and heart failure.			transfers initiated on 4/25/24,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155593	B. W	ING		09/20/	/2024
							
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					EEMASON PARKWAY		
COMPAS	SS PARK			FRANK	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
					3/14/24, and 3/6/24. Resident	1	
	Resident 1 had ider	ntified a family member as the			has moderate cognitive		
	resident's guardian and emergency contact person.				impairment; therefore, a writte	n	
					copy was only provided to the		
					resident representative. Resid		
	The Quarterly Minimum Data Set (MDS)				140 was discharged from the		
		7/24/24, indicated Resident 1			facility on 7/4/24 and passed a	away	
	was moderately cognitively impaired.				at the hospital on 7/13/24. Wri	-	
	was moderatery cognitively impaired.				notices have not been provide		
	A review of Resident 1's progress notes indicated				the resident and resident		
	that Resident 1 had facility-initiated transfers out				representative for the transfer		
	to the hospital emergency department on 4/25/24,				initiated on 7/4/24. Progress n		
	3/13/24, and 3/6/24.				have been entered for each of		
	5, 15, 2 1, and 5, 6, 2 1	•			above notifications in the med		
	The clinical record lacked documentation that				records for residents 123, 1, a		
		n bed hold notification was			140.	ii G	
		sident 1 and to resident's			2 2. All facility residents ha	vina	
	_	gency contact person for these			a transfer/discharge episode h	-	
	transfers.	series continue person for these			the potential to be affected. Ar		
	u u u u u u u u u u u u u u u u u u u				audit of the past 30 days of	•	
	2. On 9/19/24 at 8:3	32 a.m., Resident 123's clinical			transfer/discharges was		
		d. The diagnoses included, but			completed and all appropriate		
		cirrhosis of the liver, anxiety,			notifications were made and		
		y disorder, and dementia.			documented in each resident's	8	
		,,			progress notes (See attachme		
	Resident 123 had id	lentified an emergency contact			C).	,,,,	
	person.	5 7			3 3. A facility Bed Hold Pol	icv	
	1				has been established (See	,	
	The Ouarterly MDS	S assessment, dated 7/2/24,			attachment D). Written copies	of	
		123 was moderately			the Bed Hold Policy will be	·.	
	cognitively impaire	-			available at each nursing stati	on in	
					the facility and will be sent with		
	A review of Reside	nt 123's progress notes			residents requiring a		
		123 had a facility-initiated			facility-initiated transfer.		
		ospital emergency department			Documentation of this will be	done	
	on 8/11/24.				using the "Emergency	=	
					Transfer/Therapeutic Leave"		
	The clinical record	lacked documentation that			progress note (See attachmer	nt E)	
		n bed hold notification was			that was created in the facility	,	
	given or sent to Res	sident 123 and to resident's			EMR system. The Social Serv		
	51.011 of bent to Rea	120 una to rediuent b	1		Living Systems. The Oddian Octo	1000	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	ETED
		155593	B. WIN	G		09/20/	2024
		1	 	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			EEMASON PARKWAY		
COMPAS	SS PARK		FRANKLIN, IN 46131				
	1			1	, 10101	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	gency contact person for this			Director will continue tracking		
	transfer.				transfer/discharges with the		
					"Notice of Transfer/Discharge	-	
		12 p.m., Resident 140's clinical			(reference attachment A). The	log	
		d. The diagnoses included, but			has been updated to include		
		COPD (chronic obstructive			documentation of written		
		, chronic respiratory failure,			notification of transfer/dischar	ge	
		otension (a type of low blood			and bed hold policy to the		
	_	urs when standing up after			resident, resident representati	ve,	
	sitting or lying dow	m).			and the Ombudsman. A new		
					progress note template titled "		
	Resident 140 had identified a family member as the				NOTD/Bed Hold Notification" (
	resident's emergency contact person.				attachment F) has been create		
					for social services to documer	nt	
	The Admission MDS assessment, dated 6/17/24,				written notification of		
	indicated Resident	140 was cognitively intact.			transfer/discharge and bed ho		
					policy to the resident, resident		
		nt 140's progress notes			representative and Ombudsma	an	
		140 had a facility-initiated			and will be used to document		
		ospital emergency department			notifications for each		
	on 7/4/24.				facility-initiated transfer. An au		
					titled "Notice of Transfer/Disch	narge	
		lacked documentation that			and Bed Hold Policy Audit"		
		n bed hold notification was			(reference attachment B) has	been	
		sident 140 and to resident's			implemented and will be		
	_	gency contact person for this			completed with each new		
	transfer.				facility-initiated transfer/discha		
					The audit will be completed by		
	_	v on 9/19/24 at 1:50 p.m., Social			Director of Nursing or designe		
		that the facility had not			Nurses will be educated to ser		
		n documentation of bed hold			written copy of the facility Bed		
		sident 1, Resident 123, or			Hold Policy with each resident		
		residents or to the residents'			requiring a facility-initiated trar	nsfer	
	representatives.				and to follow up with		
					documentation in the clinical		
	_	y on 9/19/24 at 2:25 p.m., the			record using the "Emergency		
	Director of Nursing Services (DNS), indicated that				Transfer" progress note. Educ	ation	
	-	specific bed hold policy and			will be completed by October		
		tled Medical or Therapeutic			18th, 2024 (See attachment L	for	
	Leave Policy, dated	1 6/15/23, and indicated it was			education content).		

i f		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155593	B. W	ING		09/20/	2024
NAME OF B	DOMBER OF CHIRD IED			STREET .	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				REEMASON PARKWAY		
COMPAS	SS PARK			FRANK	KLIN, IN 46131		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG			DATE
		in use and most closely d notification policy. The			4 4. The "Notice of Transfer/Bed Hold Audit" will be	20	
		t for medical or therapeutic			completed for each facility-init		
		, the facility acted in			transfer/discharge. Results of		
	accordance with Fed				audit will be reviewed in the fa		
	guidelines.	dorar and state			Quality Assurance and	Cility	
	53140111105.				Performance Improvement		
	3.1-12(a)(25)				meetings for the next 6 month	S.	
	3.1-12(a)(26)				meetinge for the merit	·.	
E 0055	400 04()(4) (0)						
F 0655 SS=D	483.21(a)(1)-(3)	_					
Bldg. 00	Baseline Care Pla	n					
-	Based on interview	and record review, the facility	F 0	655	1 1. The care plan for resid	ent	10/18/2024
	failed to ensure a ba	aseline care plan was			82 was updated on 9/19/24 to		
	developed for 1 of 5	5 residents reviewed for new			include the need for Enhanced	t	
	admissions. The ba	seline care plan lacked a			Barrier Precautions.		
	information on Enha	anced Barrier Precautions.			2 2. All residents with wour	nds	
	(Resident 82)				(ex: chronic wounds such as		
					pressure ulcers, diabetic foot		
	Finding includes:				ulcers, unhealed surgical wou and chronic venous stasis ulce		
	On 9/19/24 at 1:25	p.m., Resident 82's clinical			and/or indwelling medical devi	,	
	record was reviewed	-			(ex: central lines, dialysis		
	Assessment, dated 7	7/25/24, indicated Resident 82			catheters, urinary catheters,		
	had a feeding tube a	and a suprapubic catheter.			feeding tubes, tracheostomy		
					tubes), and infection or		
		lan (baseline care plan), dated			colonization with any resistant		
		Resident 82 had a feeding tube			organisms targeted by the CD		
		theter. The Interim Care Plan			and important epidemiological	-	
		regarding Enhanced Barrier			important MDRO when contact		
	Precautions.				precautions do not apply have		
	0.0/10/01 0.55	d Boyl "			potential to be affected. An au	dít	
	_	p.m., the DON indicated			of current residents was		
		ine Care Plan should have			completed to identify those in		
		lent 82 required Enhanced			need of Enhanced Barrier		
	Barrier Precautions.				Precautions. Each of those		
	2.1.20()				residents was then included in		
	3.1-30(a)				audit titled "Residents Current	ly	
					Requiring Enhanced Barrier		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15593 NAME OF PROVIDER OR SUPPLIER COMPASS PARK ISSUMMARY STATEMENT OF DEFICIENCY PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG IDENTIFICATION MIST REPRICEDED BY PILLL TAG PREGULATORY OR LSC IDENTIFYING INFORMATION TAG PREGULATORY OR LSC IDENTIFYING INFORMATION PREGULATORY (See attachment G) to ensure the reason for EBP was noted in the clinical record, the care plan for EBP was in place, and the door signage/cart was in place outside of the resident room. Audit completed 1071724. 3 3 The "EBP Audit New Admissions, Additions, Removals" (See attachment H) has been implemented for tracking of new residents needing Enhanced Barrier Precautions, any existing residents that have a change requiring implementation of EBP, and any existing residents that have a change requiring implementation of EBP, and any existing residents that have a change that no longer requires EBP. The "EBP Audit New Admissions, Additions, Removals" will be completed with each required change. Results of the audit will be reviewed in the facility Quality Assurance and Performance Improvement meetings for the next 6 months.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY			
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SS=D Infection Prevention & Control Bldg. 00	F 0880	483.80(a)(1)(2)(4)(e)(f)					
	Bldg. 00							
				F 0880	1 1. Resident 82 had r	10	10/18/2024	
interview, the facility failed to ensure the infection adverse effects from the deficient		· ·						
control practices were implemented for 1 of 8 practice. Signage and PPE		_	-					
residents observed with Enhanced Barrier supplies were already outside of					_ · · · · · · · · · · · · · · · · · · ·			
Precautions (EPB). Personal Protective Equipment the resident room and a gown was (PPE) was not used to administer medications via donned during the care procedure.					-			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2024	
NAME OF P	ROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 800 FREEMASON PARKWAY FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	 	ID	I		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		resident on EPB. (Resident 82)			2 2. All residents requiring		
					Enhanced Barrier Precautions		
	Finding Includes:				have the potential to be affected		
	During an observation on 9/18/24 at 8:47 a.m., LPN				An audit of current residents w		
					completed to identify those in	uo	
		ions to be administered via a			need of Enhanced Barrier		
		2 took the medications into			Precautions. Each of those		
	Resident 82's room, closed the door for privacy,				residents was then included in	the	
	washed her hands, and applied gloves. LPN 2 had				audit titled "Residents Current		
	begun to administer the medications. LPN 2 was				Requiring Enhanced Barrier	,	
	queried if Resident 82 was on EBP. LPN 2 stopped				Precautions" (reference		
	and walked over to supplies of PPE and put on a				attachment G) to ensure the		
	gown.				reason for EBP was noted in t	he	
					clinical record, the care plan for	or	
	During an observat	ion on 9/16/24 at 9:50 a.m., an			EBP was in place, and the do	or	
	Enhanced Barrier P	Precaution Sign was posted on			signage/cart was in place outs	ide	
	the outside of Resid	dent 82's room.			of the resident room.		
					3 3. An audit titled "Enhand	ed	
	-	v on 9/18/24 at 1:04 p.m., the			Barrier Precautions Compliand	ce	
	_	g (DON) indicated that all staff			Audit" (See attachment I) has		
	_	and gown with direct care for			been implemented and is used		
	resident's on EPB.				observe staff compliance with		
					for those residents requiring E		
		4 a.m., the DON provided a copy			Observations will be complete	d at	
		ection Control Policy,			a rate of 15 per week for 3	•	
		Precautions, revised 3/2024 and			months, then 10 per week for	3	
		current policy in use by the			months, then auditing will be	l la a	
	-	of the polity indicated:			discontinued. Nursing staff wil		
		Precautions refer to the use of			educated on the facility policy		
	_	or use during high-contact ties for residents known to be			Enhanced Barrier Precautions		
		ed with multi drug resistant			Education will be completed b October 18th, 2024 (See	у	
		as those at increased risk of			attachment L for education		
		(residents with wounds or			content).		
	indwelling medical	•			4 4. The audit titled "Enhan	ced	
	ma, ching mealear	. 22 . 2200).			Barrier Precautions Compliand		
	3.1-18(b)(1)				Audit" will be completed with		
	(-)(*)				observations at a rate of 15 pe	er	
					week for 3 months, then 10 pe		
					week for three months, then		
					1		I

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/20/2024	
NAME OF 1	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
COMPAS	SS PARK				REEMASON PARKWAY KLIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	discontinue. Results of the au	J:+	DATE
					will be reviewed in the facility Quality Assurance and Performance Improvement meetings for the next 6 month		
F 9999							
Bldg. 00							
	each employee of a prior to employmer include a tuberculir method (5 TU PPD having documentated department-approve intradermal tubercular recording unless a part can be documented in millimeters of induction date read, and by we tuberculin skin test employee starting with the following: (1) At the time of employee facilities shall be so health care workers documented negative during the precediments.	cination shall be required for facility within one (1) month at. The examination shall a skin test, using the Mantoux administered by persons ion of training from a ed course of instruction in a skin testing, reading, and previously positive reaction. The result shall be recorded duration with the date given, shom administered. The must be read prior to the work. The facility must assure temployment, or within one (1) loyment, and at least annually es and nonpaid personnel of the reened for tuberculosis. For who have not had a we tuberculin skin test result g twelve (12) months, the skin testing should employ the	F 99	999	1 1. An audit was completed the employee files for NA 5 and NA 7 and the tuberculin two-structure process was restarted as necessary. 2 2. All nurse aide students have the potential to be affected. An audit of each nurse aide employee file from the affected class (July 2024 class) as well the following class (August 20 class) was completed. There was affected nurse aides from the class. Those nurse aides have restarted the two-step process. There were no affected nurse aides from the August class. 3 3. Nurse aide employees receive their first step tubercul skin test during their new employee orientation. The nur aide class instructor will be responsible for making sure the tuberculin skin tests are read a documented 48-72 hours after	d dep dep dep dep dep dep dep dep dep de	10/18/2024
	second test should by (3) weeks after the repeat testing will detect the second test should be second test sho	f the first step is negative, a be performed one (1) to three first step. The frequency lepend on the risk of infection			placement. The nurse aide cla instructor will maintain the documentation papers for tuberculin skin testing and ens	sure	
	with tuberculosis.				the second step tuberculin tes are administered 7-21 days af		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155593	B. WI	NG		09/20/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					EEMASON PARKWAY		
COMPAS	SS PARK			FRANK	LIN, IN 46131		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
		not met as evidenced by:			the initial step. Subsequently,	the	
		Ž			nurse aide class instructor will		
	Based on interview	and record review the facility			ensure the second step tubero		
		f completed a two-step			skin test is read and documen		
	tuberculin skin test prior to employment for 2 of 3				48-72 hours after placement.		
	employees reviewed				instructor will forward a copy of		
					records to Human Resources		
	On 9/20/24 at 10:00	0 a.m., the Nurse Aide Training			once the two-step process has	6	
	records were review				been completed. The nurse air		
					class instructor will maintain a		
	1. Nurse Aide (NA) 5 started Nurse Aide training at the facility on 7/18/24. A first step tuberculin				audit titled "NA Class Tubercu	lin	
					Skin Test Audit" (See attachm	ent	
	skin test was placed in the NA's left forearm on				K) for each nurse aide class		
	•	dent file lacked documentation			completed.		
	of a second step tub	erculin skin test.			4 4. The nurse aide class		
	1				instructor will maintain an audi	t	
	On 9/20/24 at 11:30	a.m., the DON indicated the			titled "NA Class Tuberculin Sk		
		skin test was incomplete for			Test Audit" for each nurse aide		
	NA 5.	•			class provided. Results of the		
					audit will be reviewed in the fa	cility	
	2. NA 7 started Nur	se Aide training at the facility			Quality Assurance and	,	
	on 7/18/24. NA 7's				Performance Improvement		
	documentation of a	first step or a second step			meetings for the next 6 months	S.	
	tuberculin skin test.				3		
	On 9/20/24 at 11:30	a.m., the DON indicated the					
		to provide documentation of					
	•	nd step tuberculin skin test.					
		-					
	On 9/20/24 at 11:45	a.m., the DON provided a					
		ulin Skin Testing for Staff,					
		and indicated it was the current					
		y the facility. A review of the					
		a. at the time of employment,					
		ndergo pre-placement					
		berculosis]b. All new staff					
		antoux TB skin tests given					
	two weeks apart"	8					
	1						

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