STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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. Survey dates: September 16, 17, 18, 19, and 20, 2024 Facility number: 001133 Provider number: 155593 AIM number: 200090430 Census Bed Type: SNF/NF: 145 SNF: 2 Total: 147 Census Payor Type: Medicare: 9 Medicaid: 84 Other: 54 Total: 147 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 24, 2024.	F 0000	Indiana Masonic Home Credible Allegation of Compliance The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc (the "facility") that the findings and allegation contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This 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 comprehensive 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 stature only.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure that written notification was provided to the resident, the resident's representative, and to the Office of the State	F 0623	1 1. The resident representative of resident 123 was provided a written copy of the Notice of Transfer/Discharge for	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marissa Meahl	RN Director of Nursing	10/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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
	Long-Term Care Ombudsman for 3 of 5 residents reviewed for written transfer and discharge notification. (Resident 140, Resident 1, Resident 123) Findings include: 1. On 9/18/24 at 2:12 p.m., Resident 140's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), chronic respiratory failure, and orthostatic hypotension (form of low blood pressure that happens when standing after sitting or lying down). Resident 140's face sheet had identified a family member as the emergency contact person. A progress note, dated 7/4/24 at 2:19 p.m., indicated Resident 140 was transferred to the hospital emergency department. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written notification of the Notice of Transfer or Discharge document was provided to Resident 140, the emergency contact, and the Office of the State Long-Term Care Ombudsman for the hospital transfer on 7/4/24. 2. On 9/19/24 at 10:00 a.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes, acute and chronic respiratory failure, and heart failure. Resident 1's face sheet had identified a family member as the guardian and emergency contact person. A progress note, dated 4/25/24 at 10:10 a.m.,		the transfer initiated on 8/11/24. A written copy of the Notice of Transfer/Discharge for the transfer initiated on 8/11/24 was also provided to the Ombudsman. Resident 123 has moderate cognitive impairment; therefore, a written copy was only provided to the resident representative and the Ombudsman. The resident representative of resident 1 was provided a written copy of the Notice of Transfer/Discharge for the transfers initiated on 4/25/24, 3/14/24, and 3/6/24. A written copy of the Notice of Transfer/Discharge for the transfers initiated on 4/25/24, 3/14/24, and 3/6/24 was also provided to the Ombudsman. Resident 1 has moderate cognitive impairment; therefore, a written copy was only provided to the resident representative and the Ombudsman. Resident 140 was discharged from the facility on 7/4/24 and passed away at the hospital on 7/13/24. Written notices were provided to the resident and resident representative for the transfer initiated on 7/4/24 at the time of the transfer. Written notification of the transfer for resident 1 for the transfer initiated on 7/4/24 was provided to the Ombudsman. Progress notes have been entered for each of the above notifications in the medical records for residents 123, 1, and 140.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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 Resident 1's emergency contact transported Resident 1 from the facility to the hospital emergency department. The transfer was a facility-initiated transfer. A progress note, dated 3/13/24 at 2:59 p.m., indicated Resident 1 was scheduled to be transferred to the hospital on 3/14/24 and was to be admitted to the hospital. The transfer was a facility-initiated transfer. A progress note, dated 3/6/24 at 2:44 p.m., indicated Resident 1 was transferred to the hospital emergency department on 3/6/24. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written notification of the Notice of Transfer or Discharge documents were provided to Resident 1, the emergency contact, and the Office of the State Long-Term Care Ombudsman for the hospital transfers on 4/25/24, 3/14/24, and 3/6/24. 3. On 9/19/24 at 8:32 a.m., Resident 123's clinical record was reviewed. The diagnoses included, but were not limited to, cirrhosis of the liver, anxiety, schizoid personality disorder, and dementia. Resident 123's face sheet had identified an emergency contact person. A progress note, dated 8/11/24 at 9:24 p.m., indicated Resident 123 was transferred to the hospital emergency department. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written notification of the Notice of Transfer or Discharge document was provided to Resident		2 2. All facility residents with a transfer-discharge episode have the potential to be affected. An audit of the past 30 days of transfer/discharges was completed and all appropriate notifications were made and documented in each resident's progress notes. 3 3. The Social Services Director will continue tracking transfer/discharges with the "Notice of Transfer/Discharge Log" (See attachment A). The log has been updated to include documentation of written notification of transfer/discharge to the resident, resident representative, and the Ombudsman. A new progress note template has been created for social services to document written notification of transfer/discharge to the resident, resident representative and Ombudsman and will be used to document notifications for each facility-initiated transfer. An audit titled "Notice of Transfer/Discharge and Bed Hold Audit" (See attachment B) has been implemented and will be completed for each new facility-initiated transfer/discharge. The audit will be completed by the Director of Nursing or designee. 4 4. The "Notice of Transfer/Discharge Audit" will be completed for each facility-initiated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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
	123, the emergency contact, and the Office of the State Long-Term Care Ombudsman for the hospital transfer on 8/11/24. During an interview on 9/19/24 at 1:54 p.m., Social Services 4 indicated the facility had not provided written notification 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 Therapeutic Leave Policy, dated 6/6/2007, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...it is the policy of this campus...residents [leaving for]...the facility for...medical reasons...in accordance with Federal and State guidelines..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		transfer/discharge. Results of the audit will be reviewed in the facility Quality Assurance and Performance Improvement meetings for the next 6 months.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure a written bed hold notification was provided to the resident and to the resident's representative for 3 of 5 residents reviewed for bed hold notifications. (Resident 1, Resident 123, and Resident 140) Findings include: 1. On 9/16/24 at 10:55 a.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes, acute and chronic respiratory failure, and heart failure.	F 0625	1 1. The resident representative of resident 123 was provided a written copy of the facility Bed Hold Policy for the transfer initiated on 8/11/24. Resident 123 has moderate cognitive impairment; therefore, a written copy was only provided to the resident representative. The resident representative of resident 1 was provided a written copy of the Bed Hold Policy for the transfers initiated on 4/25/24,	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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 1 had identified a family member as the resident's guardian and emergency contact person. The Quarterly Minimum Data Set (MDS) assessment, dated 7/24/24, indicated Resident 1 was moderately cognitively impaired. A review of Resident 1's progress notes indicated that Resident 1 had facility-initiated transfers out to the hospital emergency department on 4/25/24, 3/13/24, and 3/6/24. The clinical record lacked documentation that indicated the written bed hold notification was given or sent to Resident 1 and to resident's guardian and emergency contact person for these transfers. 2. On 9/19/24 at 8:32 a.m., Resident 123's clinical record was reviewed. The diagnoses included, but were not limited to, cirrhosis of the liver, anxiety, schizoid personality disorder, and dementia. Resident 123 had identified an emergency contact person. The Quarterly MDS assessment, dated 7/2/24, indicated Resident 123 was moderately cognitively impaired. A review of Resident 123's progress notes indicated Resident 123 had a facility-initiated transfer out to the hospital emergency department on 8/11/24. The clinical record lacked documentation that indicated the written bed hold notification was given or sent to Resident 123 and to resident's		3/14/24, and 3/6/24. Resident 1 has moderate cognitive impairment; therefore, a written copy was only provided to the resident representative. Resident 140 was discharged from the facility on 7/4/24 and passed away at the hospital on 7/13/24. Written notices have not been provided to the resident and resident representative for the transfer initiated on 7/4/24. Progress notes have been entered for each of the above notifications in the medical records for residents 123, 1, and 140. 2 2. All facility residents having a transfer/discharge episode have the potential to be affected. An audit of the past 30 days of transfer/discharges was completed and all appropriate notifications were made and documented in each resident's progress notes (See attachment C). 3 3. A facility Bed Hold Policy has been established (See attachment D). Written copies of the Bed Hold Policy will be available at each nursing station in the facility and will be sent with residents requiring a facility-initiated transfer. Documentation of this will be done using the "Emergency Transfer/Therapeutic Leave" progress note (See attachment E) that was created in the facility EMR system. The Social Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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
	guardian and emergency contact person for this transfer. 3. On 9/18/24 at 2:12 p.m., Resident 140's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure, and orthostatic hypotension (a type of low blood pressure which occurs when standing up after sitting or lying down). Resident 140 had identified a family member as the resident's emergency contact person. The Admission MDS assessment, dated 6/17/24, indicated Resident 140 was cognitively intact. A review of Resident 140's progress notes indicated Resident 140 had a facility-initiated transfer out to the hospital emergency department on 7/4/24. The clinical record lacked documentation that indicated the written bed hold notification was given or sent to Resident 140 and to resident's guardian and emergency contact person for this transfer. During an interview on 9/19/24 at 1:50 p.m., Social Service 4 indicated that the facility had not provided any written documentation of bed hold notifications for Resident 1, Resident 123, or Resident 140 to the residents or to the residents' representatives. During an interview on 9/19/24 at 2:25 p.m., the Director of Nursing Services (DNS), indicated that the facility lacked a specific bed hold policy and provided a policy titled Medical or Therapeutic Leave Policy, dated 6/15/23, and indicated it was		Director will continue tracking transfer/discharges with the "Notice of Transfer/Discharge Log" (reference attachment A). The log has been updated to include documentation of written notification of transfer/discharge and bed hold policy to the resident, resident representative, and the Ombudsman. A new progress note template titled "SS NOTD/Bed Hold Notification" (See attachment F) has been created for social services to document written notification of transfer/discharge and bed hold policy to the resident, resident representative and Ombudsman and will be used to document notifications for each facility-initiated transfer. An audit titled "Notice of Transfer/Discharge and Bed Hold Policy Audit" (reference attachment B) has been implemented and will be completed with each new facility-initiated transfer/discharge. The audit will be completed by the Director of Nursing or designee. Nurses will be educated to send a written copy of the facility Bed Hold Policy with each resident requiring a facility-initiated transfer and to follow up with documentation in the clinical record using the "Emergency Transfer" progress note. Education will be completed by October 18th, 2024 (See attachment L for education content).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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 policy currently in use and most closely related to a bed hold notification policy. The policy indicated that for medical or therapeutic leaves for residents, the facility acted in accordance with Federal and State guidelines. 3.1-12(a)(25) 3.1-12(a)(26)		4 4. The "Notice of Transfer/Bed Hold Audit" will be completed for each facility-initiated transfer/discharge. Results of the audit will be reviewed in the facility Quality Assurance and Performance Improvement meetings for the next 6 months.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on interview and record review, the facility failed to ensure a baseline care plan was developed for 1 of 5 residents reviewed for new admissions. The baseline care plan lacked a information on Enhanced Barrier Precautions. (Resident 82) Finding includes: On 9/19/24 at 1:25 p.m., Resident 82's clinical record was reviewed. The Admission Assessment, dated 7/25/24, indicated Resident 82 had a feeding tube and a suprapubic catheter. The Interim Care Plan (baseline care plan), dated 7/25/24, indicated Resident 82 had a feeding tube and a suprapubic catheter. The Interim Care Plan lacked information regarding Enhanced Barrier Precautions. On 9/19/24 at 2:30 p.m., the DON indicated Resident 82's Baseline Care Plan should have indicated that Resident 82 required Enhanced Barrier Precautions. 3.1-30(a)	F 0655	1 1. The care plan for resident 82 was updated on 9/19/24 to include the need for Enhanced Barrier Precautions. 2 2. All residents with wounds (ex: chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (ex: central lines, dialysis catheters, urinary catheters, feeding tubes, tracheostomy tubes), and infection or colonization with any resistant organisms targeted by the CDC and important epidemiologically important MDRO when contact precautions do not apply have the potential to be affected. An audit of current residents was completed to identify those in need of Enhanced Barrier Precautions. Each of those residents was then included in the audit titled "Residents Currently Requiring Enhanced Barrier	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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
			Precautions" (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 10/7/24. 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 that no longer requires EBP. The "EBP Audit – New Admissions, Additions, Removals" will be completed by the Director of Nursing or designee. 4 4. The audit titled "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.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure the infection control practices were implemented for 1 of 8 residents observed with Enhanced Barrier Precautions (EPB). Personal Protective Equipment (PPE) was not used to administer medications via	F 0880	1 1. Resident 82 had no adverse effects from the deficient practice. Signage and PPE supplies were already outside of the resident room and a gown was donned during the care procedure.	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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
	a feeding tube for a resident on EPB. (Resident 82) Finding Includes: During an observation on 9/18/24 at 8:47 a.m., LPN 2 prepared medications to be administered via a feeding tube. LPN 2 took the medications into Resident 82's room, closed the door for privacy, washed her hands, and applied gloves. LPN 2 had begun to administer the medications. LPN 2 was queried if Resident 82 was on EBP. LPN 2 stopped and walked over to supplies of PPE and put on a gown. During an observation on 9/16/24 at 9:50 a.m., an Enhanced Barrier Precaution Sign was posted on the outside of Resident 82's room. During an interview on 9/18/24 at 1:04 p.m., the Director of Nursing (DON) indicated that all staff should wear gloves and gown with direct care for resident's on EPB. On 9/18/24 at 11:04 a.m., the DON provided a copy of policy titled, Infection Control Policy, Enhanced Barrier Precautions, revised 3/2024 and indicated it was the current policy in use by the facility. A review of the polity indicated: Enhanced Barrier Precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with multi drug resistant organisms as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical devices). 3.1-18(b)(1)		2 2. All residents requiring Enhanced Barrier Precautions have the potential to be affected. An audit of current residents was completed to identify those in need of Enhanced Barrier Precautions. Each of those residents was then included in the audit titled “Residents Currently Requiring Enhanced Barrier Precautions” (reference 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. 3 3. An audit titled “Enhanced Barrier Precautions Compliance Audit” (See attachment I) has been implemented and is used to observe staff compliance with PPE for those residents requiring EBP. Observations will be completed at a rate of 15 per week for 3 months, then 10 per week for 3 months, then auditing will be discontinued. Nursing staff will be educated on the facility policy for Enhanced Barrier Precautions. Education will be completed by October 18th, 2024 (See attachment L for education content). 4 4. The audit titled “Enhanced Barrier Precautions Compliance Audit” will be completed with observations at a rate of 15 per week for 3 months, then 10 per week for three months, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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
			discontinue. Results of the audit will be reviewed in the facility Quality Assurance and Performance Improvement meetings for the next 6 months.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency repeat testing will depend on the risk of infection with tuberculosis.	F 9999	1 1. An audit was completed of the employee files for NA 5 and NA 7 and the tuberculin two-step 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 as the following class (August 2024 class) was completed. There were affected nurse aides from the July 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 will receive their first step tuberculin skin test during their new employee orientation. The nurse aide class instructor will be responsible for making sure the tuberculin skin tests are read and documented 48-72 hours after placement. The nurse aide class instructor will maintain the documentation papers for tuberculin skin testing and ensure the second step tuberculin tests are administered 7-21 days after	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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
	This State rule was not met as evidenced by: Based on interview and record review the facility failed to ensure staff completed a two-step tuberculin skin test prior to employment for 2 of 3 employees reviewed. (NA 5, NA 7) On 9/20/24 at 10:00 a.m., the Nurse Aide Training records were reviewed. 1. Nurse Aide (NA) 5 started Nurse Aide training at the facility on 7/18/24. A first step tuberculin skin test was placed in the NA's left forearm on 7/17/24. NA 5's student file lacked documentation of a second step tuberculin skin test. On 9/20/24 at 11:30 a.m., the DON indicated the two-step tuberculin skin test was incomplete for NA 5. 2. NA 7 started Nurse Aide training at the facility on 7/18/24. NA 7's student file lacked documentation of a first step or a second step tuberculin skin test. On 9/20/24 at 11:30 a.m., the DON indicated the facility was unable to provide documentation of NA 7's first or second step tuberculin skin test. On 9/20/24 at 11:45 a.m., the DON provided a policy titled Tuberculin Skin Testing for Staff, dated March 2017, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...a. at the time of employment, all new staff shall undergo pre-placement screening for TB [tuberculosis]....b. All new staff shall receive two Mantoux TB skin tests given two weeks apart..."		the initial step. Subsequently, the nurse aide class instructor will ensure the second step tuberculin skin test is read and documented 48-72 hours after placement. The instructor will forward a copy of the records to Human Resources once the two-step process has been completed. The nurse aide class instructor will maintain an audit titled “NA Class Tuberculin Skin Test Audit” (See attachment K) for each nurse aide class completed. 4 4. The nurse aide class instructor will maintain an audit titled “NA Class Tuberculin Skin Test Audit” for each nurse aide class provided. Results of the audit will be reviewed in the facility Quality Assurance and Performance Improvement meetings for the next 6 months.	