STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155797	A. BUILDING 00 B. WING	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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 and Investigation of Complaints IN00435626 an IN00436050.This visit included a State Residential Licensure Survey. Complaint IN00435626 - Federal/State deficiencies related to the allegations are cited at F677 and F692. Complaint IN00436050 - No deficiencies related to the allegations are cited. Survey dates: June 10, 11, 12, 13, and 14, 2024 Facility number: 012854 Provider number: 155797 AIM number: 201104690 Census Bed Type: SNF/NF: 33 SNF: 15 Residential: 31 Total: 79 Census Payor Type: Medicare: 13 Medicaid: 32 Other: 3 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 24, 2024.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during Annual survey conducted on June 28, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of July 5, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0554 SS=D	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kellee Couch	Executive Director	07/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Bldg. 00	§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to assess a resident to self-administer medications for 1 of 14 residents reviewed. (Resident 43) Findings include: During an observation on 06/12/24 at 9:30 A.M., Resident 43 had a medicine cup full of pills sitting on his over the bed table on his breakfast tray. No staff members were in the room. At 9:31 A.M., LPN (Licensed Practical Nurse) 5 stopped in the resident's room and told him to not forget to eat his breakfast and to take his morning medications, then left the room. Eight pills of various colors, shapes, and sizes were in the medication cup. The resident indicated one was for phantom pain, one was a blood thinner, and one was an iron pill. A second cup was on the tray filled to the top with a reddish clear fluid. During an observation and interview on 06/12/24 at 10:00 A.M., the resident's breakfast tray was still on the over the bed table. The tray had two medicine cups sitting on it, one with a small white pill the resident identified as their "water pill" that they didn't like to take so they put it off as long as they could, and a cup filled to the top with a reddish clear fluid. During an observation and interview on 06/12/24 at 11:37 A.M., the resident was sitting up on their bed. A medicine cup with a Lasix (water pill), as identified by the resident, was still sitting on the over the bed table. The resident indicated they were getting ready to take it.	F 0554	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident 43 has been assessed and deemed appropriate for self-administration of Exhibit A) The physician had been made aware and order received for resident to self-administer. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All resident medical records reviewed to ensure proper assessment and documentation is in place if they desire to administer their own medications (Exhibit B). Nursing staff educated on the “Guidelines for self-administration of medication” General Guidelines for administration of medication” (Exhibit C) 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance, the Director of Health	07/05/2024

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	During an interview on 06/13/24 at 2:49 P.M., LPN 7 indicated if a resident self-administered their medications there would be an assessment completed in "Observations" on the EHR (Electronic Health Record). They currently did not have any residents who self-administered their medications other than maybe an inhaler. They had one resident, who was not Resident 43, who liked to have their medications left at the bedside to take when they wanted to, but they had to have a self-administer assessment completed. During an interview on 06/13/24 at 3:59 P.M., LPN 7 indicated Resident 43 was bad about acting like they took their medications and picked out the ones they wanted. The resident should not have had medications left at the bedside. They did not have a Self-Administration Assessment completed in order for them to be able to have medications left at the bedside. During an interview on 06/14/24 at 9:32 A.M., the Clinical Support indicated the resident may have an order to self-administer medications, but they should also have had the assessment completed prior to self-administering their medications and she did not believe the resident had the assessment completed. The clinical record was reviewed on 06/14/24 at 11:07 A.M. An Admission MDS (Minimum Data Set Assessment), dated 05/10/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, arthritis, psychotic disorder, and history of malignant neoplasm of the kidney. The record lacked an assessment allowing the resident to safely self-administer their		Services (DHS) or designee with complete the following audits: Room rounding to ensure no medications are left at bedside daily (Exhibit D)for 5 days per week x4 weeks, then twice weekly every other week x2 months, then once monthly for 3 months. DHS or designee will review 5 residents for appropriate self-administration assessments (Exhibit E), as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	medications. The current "MEDICATION ADMINISTRATION - GENERAL GUIDELINES" policy, with a revised date of 11/18, was provided by the Clinical Support on 06/13/24 at 2:22 P.M. The policy indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices...Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications...The resident is always observed after administration to ensure that the dose was completely ingested..." The "Guidelines for Self-Administration of Medications" policy, with a reviewed date of 12/31/23, was provided by the Clinical Support on 06/14/24 at 9:55 A.M. The policy indicated, "...Residents requesting to self-medicate...shall be assessed using the observation Trilogy- Self Administration of Medication within the electronic health record...Results of the assessment will be presented to the physician for evaluation and an order for self-medication...The order should include the type of medication(s) the resident is able to self-medicate. i.e.:all oral meds, oral meds with the exception of....., nebulizer treatment only, all medications including injection, oral, inhalers, drops, etc..." 3.1-11(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral			

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	hygiene; Based on record review and interview, the facility failed to provide bathing for 2 of 3 residents reviewed for Activities of Daily Living. (Residents D and E) Findings include: 1. During an interview on 06/13/24 at 1:43 P.M., CNA (Certified Nurse Aide) 8 indicated resident showers were offered twice a week or more if they preferred. The showers were documented in the computer system or a shower sheet. The residents would be offered a shower or a bed bath and in between their shower days they were given a partial bed bath. The partial bed bath was just to wash their peri area and their arm pits. If a resident refused the shower or bed bath it would be document in the clinical record and on the shower sheets. The clinical record for Resident D was reviewed on 06/13/24 at 11:04 A.M. An Admission MDS (Minimum Data Set) assessment, dated 03/11/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and respiratory failure. The Point of Care History and the Shower Sheets indicated the resident had the following showers or complete bed baths since admission to the facility on 03/06/24: - 04/09/24, shower, - 04/02/24, shower - 03/29/24, complete bed bath - 03/26/24, shower, - 03/22/24, shower, - 03/11/24, complete bed bath.	F 0677	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident D & E provided a shower. Each resident's preferences for shower days reviewed with residents. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected by this alleged deficient practice. DHS, ED, SSD or designee will complete an audit of in-house residents to ensure showers are provided per preference and documented appropriately in medical record (Exhibit F) DHS or designee will educate the licensed nursing staff on "Guidelines for bathing preference" and "Nursing ADL documentation guidelines". (Exhibit G). 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance, the DHS or designee will be responsible for auditing residents receiving showers per	07/05/2024

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	The resident had 6 out of 10 showers, complete bed baths, or refusals from admission to discharge on 04/08/24. 2. The clinical record for Resident E was reviewed on 06/12/24 at 3:08 P.M. An Admission MDS assessment, dated 03/12/24, indicated the resident was cognitively intact. The diagnoses for the resident, included but were not limited to, fracture of the right fibula, anemia, hypertension, and diabetes. During an interview on 06/14/24 at 2:19 P.M., LPN (Licensed Practical Nurse) 7 indicated the resident was non-compliant with care at times. He refused his showers and liked to use the bed pan. The refusal of showers was to be documented in the computer charting or on a shower sheet. The Point of Care History and the Shower Sheets indicated the resident had the following showers, refusals, or complete bed baths from admission on 03/07/24 through 04/30/24: - 03/07/24, complete bed bath, - 03/15/24, refused, - 03/16/24, complete bed bath, - 03/19/24, shower, - 03/22/24, refused, - 03/26/24, refused, - 03/29/24, shower, - 04/02/24, shower, - 04/12/24, refused, - 04/16/24, shower, and - 04/22/24, shower. The resident was given or offered a bath or shower 11 of 15 times from 03/07/24 through 04/30/24.		preference and per policy (Exhibit H) Audit of 5 residents will be conducted 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	The current facility policy, titled "Guidelines for Bathing Preference" with a review date of 12/31/23, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, "...Bathing shall occur at least twice a week unless resident preference states otherwise..." The current facility policy, titled "Nursing ADL Documentation Guidelines" with a review date of 12/31/23, was provided by the Clinical Nurse Consultant on 05/08/24 at 2:51 P.M. The policy indicated, "To document the type and amount of assistance provided to the resident for activities of daily living...Completion of ADL service will be validated through the use of the CARE ASSIST ADL reports...ADL services will be conducted and documented by the CNA each shift at the [point of care] or as reasonably possible after care..." This citation relates to Complaint IN00435626. 3.1-38(a)(2)(A)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-			

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	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to indwelling urinary catheters for a resident who had a history of UTIs (Urinary Tract Infections) for 1 of 3 residents reviewed for urinary catheters / UTIs. (Resident 34) Findings include: During an observation on 06/11/24 at 10:39 A.M., Resident 34 was in their wheelchair propelling themselves and exiting their bathroom. Two to three inches of their indwelling urinary catheter tubing was dragging on the floor under their wheelchair.	F 0690	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. with indwelling catheters have the potential to be affected by this alleged deficient practice. An audit of with indwelling catheters has been completed with	07/05/2024

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	During an observation on 06/11/24 at 10:44 A.M., the resident was sitting in their wheelchair in their room. Their urinary catheter tubing contained tan colored pieces of debris approximately 2 to 3 mm (millimeters) in length and width. During an observation on 06/11/24 at 1:34 P.M., the resident was in the Therapy Gym sitting in his wheelchair. Part of his indwelling urinary catheter bag and tubing were touching the floor. During and observation and interview on 06/12/24 at 10:03 A.M., the resident was in their wheelchair in their room. Their urinary catheter bag was touching the floor as was 6 to 8 inches of the catheter tubing. The tubing contained cloudy yellow urine. The resident indicated a staff member had put medicine in their catheter earlier that morning. They were able to get themselves into their wheelchair but needed staff's help hanging their urinary catheter bag under their wheelchair. During an observation on 06/12/24 at 3:03 P.M., the resident was in their room sitting in their wheelchair. Their urinary catheter bag and tubing were touching the floor. The urine in the catheter tubing was cloudy and yellow. During an interview on 06/12/24 at 3:15 P.M., the Therapy Manager indicated the resident did not transfer by themselves. They had been discharged from therapy as a one person assist. During an interview and observation on 06/12/24 at 3:18 P.M., CNA (Certified Nurse Aide) 3 indicated the resident required the assistance of one staff member when using the bathroom and getting ready for bed. They needed help pivoting and transferring. While observing the resident in		interventions for secure and safe positioning of tubing and Exhibit I staff has been educated on “Urinary Catheter care” and securing the tubing and bag off the floor. (Exhibit J) 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DHS or will be responsible for ensuring secure and safe positioning of catheter tubing and bag. (exhibit K) Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? ¿For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly	

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	their room, the CNA indicated the urinary catheter bag and tubing should not be touching the floor. The clinical record was reviewed on 06/12/24 at 3:08 P.M. An Annual MDS (Minimum Data Set) assessment, dated 05/31/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, neurogenic bladder, diabetes, dementia, and hemiplegia. The resident required extensive assistance of two staff members for transfers. During an interview on 06/14/24 10:15 AM., the IP (Infection Preventionist) and the MDS Coordinator indicated the resident received a bladder irrigation as a UTI prevention because they had recurrent UTIs. The physician's orders related to the resident's indwelling catheter were provided by the Clinical Support on 06/14/24 at 10:51 A.M. The orders included, but were not limited to, a current open-ended order, with a start date of 02/08/24, for Clorpactin (an antibacterial agent) flush, 60 ml (milliliters) infused in the bladder and clamped for 15 minutes. The current "Urinary Catheter Care" policy, with a reviewed date of 12/31/23, was provided by Clinical Support on 06/14/24 at 9:55 A.M. The policy indicated, "...To prevent infection of the resident's urinary tract...Be sure the catheter tubing and drainage bag are kept off the floor..." 3.1-41(a)(2)		quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration.			

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	(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to follow hospital discharge orders and verify admission weights for 1 of 3 residents reviewed for hydration/nutrition. (Resident D) Findings include: 1. The clinical record for Resident D was reviewed on 06/13/24 at 11:04 A.M. An Admission MDS (Minimum Data Set) assessment, dated 03/11/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and respiratory failure. The hospital discharge summary for the resident, dated 03/06/24, indicated the resident's heart failure instructions for daily management was to be weighed daily on the same scale and at	F 0692	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident D has been discharged. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected by this alleged deficient practice. An audit of health center residents has been completed to ensure admission diet recommendations and have been implemented. (Exhibit L	07/05/2024

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(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
	approximately the same time of day. The weight should be reported to the physician if the resident had a weight gain of three pounds in a day or five pounds in a week. The facility was to use the hospital discharge weight as a baseline reference. The facility was to continue a low sodium diet and limit the fluid intake to 1.5 to 2 liters per day. The resident's hospital discharge weight was 177 pounds. A Facility Progress Note, dated 03/06/24 at 1:30 P.M., indicated the resident arrived at the facility at 1:30 P.M. The resident's admitting diagnoses was pericardial effusion (the buildup of extra fluid in the space around the heart). The resident had a pericardial drain while in the hospital that was healed and had 1800 ml (milliliters) of fluid removed. The resident had the following weights documented while in the facility: - 03/06/24, the resident's weight was 191 pounds, - 03/11/24, the resident's weight was 189.9 pounds, - 03/18/24, the resident's weight was 190.2 pounds, - 03/25/24, the resident's weight was 190.2 pounds, - 04/01/24, the resident's weight was 164.8 pounds and 165.9 pounds, - 04/02/24, the resident's weight was 166 pounds, - 04/03/24, the resident's weight was 166 pounds, - 04/04/24, the resident's weight was 165.2 pounds, and - 04/05/24, the resident's weight was 165.2 pounds. The clinical record lacked documentation the resident was weighed daily until 04/01/24, lacked the prescribed low sodium diet, fluid intake monitoring, and lacked follow-up with the admission weight when it was different than the		nursing staff educated on admission nutrition orders and the Matrix admission checklist guidelines. (Exhibit M) 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance, the DHS or designee will be responsible for ensuring nutrition recommendations upon admission are addressed and implemented as warranted (Exhibit N) . Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? ¿For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted.	

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	hospital discharge weight. During an interview on 06/13/24 at 1:38 P.M., RN 6 indicated when a resident admitted to the facility from the hospital she would get report from the hospital. Once the resident got to the facility, she would complete a consent to treat, admission assessment, skin assessment, obtain the resident's code status, and orient the resident to their surroundings. She would review the resident's admitting physician orders and transcribe them into the clinical record. A second nurse would verify the orders and then the hospital forms would be scanned into the clinical record. During an interview on 06/13/24 at 1:42 P.M., CNA (Certified Nurse Aide) 8 indicated when a resident required a daily weight, she would obtain that weight when the resident got up in the morning. The residents could be weighed by sitting in a weight chair or by the full body lift. The facility had not had any concerns with their scales recently. If a resident had a significant weight change, she would alert the nurse on duty for the day. During an interview on 06/13/24 at 4:00 P.M., the DON (Director of Nursing) indicated if the resident's discharge paperwork indicated they were to be weighed daily, then it should have been transcribed on admission. The resident had a significant weight decrease while a resident, but his hospital discharge paperwork showed he weighed 177 pounds when he was discharged. The resident could not gain that much weight when leaving the hospital and getting to the facility. She was unsure why there was a weight difference, but it should have been addressed.		The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	The current facility policy titled "Notification of Change" with a review date of 12/31/23, was provided by the Clinical Support on 06/13/24 at 3:06 P.M. The policy indicated, "...To ensure appropriate individuals are notified of change in condition..." This citation relates to Complaint IN00435626. 3.1-46(a)(1) 3.1-46(a)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation, interview, and record review, the facility failed to appropriately store medications for 1 of 2 medication carts reviewed (300 Hall Medication Cart), and for 1 of 2 medication rooms (300 Hall Medication Room) reviewed. Findings include: 1. On 06/14/24 at 9:57 A.M., the 300 Hall Medication Cart was observed with LPN (Licensed Practical Nurse) 7 and contained the following: - A Lispro insulin pen for Resident 28. The pen was well over 3/4 full and was not labeled with an "opened on" date. During an interview on 06/14/24 at 9:59 A.M., LPN 7 indicated Resident 28 usually received insulin four times a day, so he went through insulin pens pretty quickly. The undated pen was delivered by the pharmacy on 05/13/24, but it was kept in the refrigerator until it was opened. The pen was nearly full, so she didn't think it had been in use for very long. She had not administered the insulin to the resident that morning. The insulin pen was good for 28 days after it was opened. The pen should have been labeled when it was opened. 2. The 300 Hall Medication Storage Room refrigerator was observed on 06/14/24 at 10:10 A.M., with RN 6 and contained the following: - An opened box that contained a nearly empty vial of TB (Tuberculin) serum. The vial was not labeled with an "opened on" date.	F 0761	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident 28, 159, 43, 56, 57 were all assessed with no adverse effects. The insulin pen not dated was destroyed. The TB serum not dated was destroyed. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All Medication carts and refrigerators that hold medications were audited for meds not dated when opened (Exhibit Nursing staff educated on the “Medication storage in the facility guideline” and proper labeling/storage of medication. (Exhibit 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of compliance, the DHS or designee will complete an audit of 5 medication carts or refrigerators that hold medications for unlabeled/undated medications after opening (Exhibit Q) . Audit of 5 med carts or refrigerators will be conducted 2 times a week times 4 weeks, weekly times a	07/05/2024

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	During an interview on 06/14/24 at 10:12 A.M., RN 6 indicated the TB serum was good for 30 days from the opened on date. The serum should have been dated when it was first opened. During an interview on 06/14/24 at 10:42 A.M., the Regional Corporate Support Nurse indicated several staff members were recently tested for TB with the undated serum. Resident records reviewed indicated the following residents' TB tests were performed using the unlabeled vial of TB serum: - Resident 159 received a TB test on 06/05/24, - Resident 43 received a TB test on 06/05/24, - Resident 56 received a TB test on 06/08/24, and - Resident 57 received a TB test on 06/13/24. The TB serum package insert was provided by the Administrator on 06/14/24 at 2:00 P.M. The directions for storage indicated, "...vials in use more than 30 days should be discarded..." The current facility policy, titled "MEDICATION STORAGE IN THE FACILITY", with a revision date of 11/18, was provided by the Administrator on 06/14/24 at 10:34 A.M. The policy indicated, "...When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated...a "date opened" sticker shall be placed on the medication..." 3.1-25(o)		week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? ¿For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to store food appropriately for 1 of 2 kitchen observations. Findings include: During the initial kitchen tour on 06/10/24 at 10:18 A.M., with the Dietary Manager the following was observed in a walk-in refrigerator: - five store bought chuck roasts with a use by or freeze by date of 06/06/24 for one of them, 06/07/24 for two of them, and 06/08/24 for two of them, - a metal tray that had a cantaloupe sitting in it, with a sticker on the tray that indicated "produce" with a use by date of 05/28/24, - a cart with several trays of alcohol that	F 0812	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? No residents were affected. The 5 roasts, cantaloupe, cherries, Jelly and fruit cup were wasted. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All receptacles containing food were audited for expired food by the DFS (Exhibit R). Dietary staff were educated on Food Labeling and Dating Exhibit	07/05/2024

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	contained a 3/4 full jar of maraschino cherries with a use by date of 05/24/23, - a 1/4 full jar of jelly with a use by date of 06/08/24, and - a prepared fruit cup laying on the floor that contained grapes and honey dew melon with a use by date of 06/05/24. The Dietary Manager indicated it was the responsibility of the cooks, Assistant Dietary Manager, and herself to ensure outdated foods were discarded. The refrigerator was to be checked once a day. The weekend cook was responsible for checking the refrigerators on the weekends. The current facility policy titled, "Food Labeling and Dating", with a revised date of 04/26/22, was provided by the Clinical Support on 06/14/24 at 9:55 A.M. The policy indicated, "...To provide knowledge and direction on how to properly label and date food items and food production..." 3.1-21(i)(3)		3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance DFS (director of food service) or will be responsible for auditing food storage for outdated/expired foods (Exhibit T). Audit of 5 food storage receptacles will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). 4: How be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? ¿For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will past 6 months if warranted until 100% compliance .	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00435626 and IN00436050. Complaint IN00435626 - FederalState deficiencies related to the allegations are cited at F677 and F692. Complaint IN00436050 - No deficiencies related to the allegations are cited. Survey dates: June 10, 11, 12, 13, and 14, 2024 Facility number: 012854 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 24, 2024.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during Annual survey conducted on June 28, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of July 5, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility	R 0273	1: What corrective action(s) will be	07/05/2024

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	failed to store food appropriately for 1 of 2 kitchen observations. Findings include: During the initial kitchen tour on 06/10/24 at 10:18 A.M., with the Dietary Manager the following was observed in a walk-in refrigerator: - five store bought chuck roasts with a use by or freeze by date of 06/06/24 for one of them, 06/07/24 for two of them, and 06/08/24 for two of them, - a metal tray that had a cantaloupe sitting in it, with a sticker on the tray that indicated "produce" with a use by date of 05/28/24, - a cart with several trays of alcohol that contained a 3/4 full jar of maraschino cherries with a use by date of 05/24/23, - a 1/4 full jar of jelly with a use by date of 06/08/24, and - a prepared fruit cup laying on the floor that contained grapes and honey dew melon with a use by date of 06/05/24. The Dietary Manager indicated it was the responsibility of the cooks, Assistant Dietary Manager, and herself to ensure outdated foods were discarded. The refrigerator was to be checked once a day. The weekend cook was responsible for checking the refrigerators on the weekends. The current facility policy titled, "Food Labeling and Dating", with a revised date of 04/26/22, was provided by the Clinical Support on 06/14/24 at		accomplished for those residents found to have affected by the deficient practice? No residents were affected. The 5 roasts, cantaloupe, cherries, Jelly and fruit cup were wasted. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All receptacles containing food were audited for expired food (Exhibit R). Dietary staff were educated on Food Labeling and Dating policy (Exhibit 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance DFS (Director of food service) or will be responsible for auditing receptacles that contain food for storage for outdated/expired foods (Exhibit T). Audit of 5 food storage receptacles will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months).	

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	9:55 A.M. The policy indicated, "...To provide knowledge and direction on how to properly label and date food items and food production..." 3.1-21(i)(3)		4: How be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? ¿For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will past 6 months if warranted until 100% compliance .	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview and record review, the facility failed to complete documentation for medication administration for 1 of 7 residents reviewed. (Resident 302) Findings include: The clinical record for Resident 302 was reviewed on 06/11/24 at 9:14 A.M. The resident's diagnoses	R 0296	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident 302 was assessed and not affected adversely. 2: How other residents having the potential to be affected by the same deficient practice will be	07/05/2024

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	included, but were not limited to, dementia, neuropathy, and anxiety. The resident's physician orders included an order, with a start date of 06/04/24 and an end date of 06/10/24, for lorazepam (an anti-anxiety medication) gel, 1 mg (milligram) per ml (milliliter). Nursing staff were to administer 1/2 packet (0.5 ml) topically, every six hours as needed. The controlled substance sign out sheet for the topical lorazepam was provided by the DON (Director of Nursing) on 06/11/24 at 9:14 A.M. The sign out sheet indicated the medication was administered on the following dates and times: 06/06/24 at 8:20 P.M., 06/09/24 at 10:00 A.M., and 06/09/24 at 8:00 P.M. The EMAR (Electronic Medication Administration Record) documentation indicated the medication was administered on 06/06/24 at 8:20 P.M. The EMAR lacked documentation of the medication administration on 06/09/24 at 10:00 A.M., and at 8:00 P.M. During an interview on 06/11/24 at 10:47 A.M., LPN (Licensed Practical Nurse) 2 indicated the lorazepam did not appear to have been documented on the EMAR every time the medication was administered. During an interview on 06/11/24 at 11:02 A.M., the DON indicated when controlled medications were administered, they should be documented on the EMAR and documented on the controlled substance sign out sheet. The current facility policy, titled "AL-Medication and Treatment Records Guidelines", with a		identified and what corrective action will be taken. All residents that are administered controlled drugs have the potential to be affected by this alleged deficient practice. All residents with controlled substances were audited for nurses' signature comparing the EMAR (Electronic Medical Administration Record) to the controlled substance sign out sheet (Exhibit U) Nursing staff were educated on the "AL Medication and treatment Guidelines" concentration on signing both the EMAR and controlled count) 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance, the DHS or designee will audit EMARs against the controlled substance sign out sheets (Exhibit W) 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? ¿For quality assurance, The ED and/or Designee will review any findings, and	

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ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

(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
	reviewed on date of 12/31/23, was provided by the DON on 06/11/24 at 2:11 P.M. The policy indicated, "...Medication and treatment records will have documentation of administration of medications (eMAR) and treatments, indicated the time, name of medication or treatment, dosage (if applicable), and the name or initials of the person administering the drug or treatment within the electronic health record...The nurse administering the medications shall record the time the medication was administered along with his/her initials..."		subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.¿Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	