

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Timbers of Jasper The		STREET ADDRESS, CITY, STATE, ZIP CODE 2909 Howard Dr Jasper, IN 47546	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident safety during transportation for 2 of 3 residents reviewed for dementia care. Locked memory care unit residents with a history of falls and/or behaviors were transported to outside appointments without being signed out and without adequate supervision. (Resident B, Resident C) Findings include: 1. Observation on 7/8/26 at 9:40 A.M., Resident B was sitting up in a Broda (high back) wheelchair in common dining/activity area. A review of grievances on 7/8/26 at 10:30 A.M., included a concern dated 6/8/26 at 9:00 A.M. from a family member regarding Resident B not having a facility attendant during a transportation / Leave of Absence (LOA) appointment. Record review on 7/8/26 at 10:45 A.M., indicated Resident B's diagnoses included but were not limited to Alzheimer's disease, dementia, anxiety, and repeated falls. The most recent quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated the resident was rarely to never understood, cognition skills were severely impaired, was dependent for activities of daily living and mobility, and had one fall with injury since the previous assessment. Resident B's care plan included but was not limited to Resident has a history of attempting to climb out of Broda chair (created 04/16/2026), Resident has a history of standing quickly from her chair and attempting to run, or attempting to crawl out of recliner (created 6/20/24), Resident often chooses to attempt to ambulate on her own, despite safety concerns. Resident cognition severely impaired which hinders safety awareness (created 5/21/24), and Resident is at risk for falls due to weakness, decreased mobility, impaired cognition, poor safety awareness altered awareness of immediate physical environment, impulsive, lack of understanding of one's physical and cognitive limitations, history of self transfers, history of rolling out of bed, and history of falling out of Broda chair (created 11/15/23). Progress notes included but were not limited to: 4/5/26 at 5:09 P.M. - Resident fell unwitnessed out of chair in common area of memory care unit. cottage. Resident being transferred to ER via ambulance. 4/15/26 at 6:30 A.M. - Resident restless and attempting to climb out of Broda chair. 4/24/26 at 5:18 P.M. - Resident restless and trying to climb out of Broda chair. 6/8/26 at 10:00 A.M. - Contracted transportation service arrived to facility at 7:50 A.M. to pick up resident for an appointment scheduled at 9:30 A.M. Just before 8:15 A.M., [office name] contacted facility and stated that resident had arrived for scheduled appointment 90 minutes early. Facility staff left facility at 8:15 A.M. to sit with resident until resident's daughter arrived at appointment. Interview on 7/8/26 at 1:30 P.M., the Memory Care Social Service Assistant indicated facility staff typically went with the memory care residents to their outside appointments if a family member could not accompany the resident. On 6/8/26 Resident B was picked up for her appointment by a contracted transportation service approximately one hour early. A family member was expected to meet the Resident B at the appointment, however the resident was dropped off for the appointment (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to the family member arriving and without a facility staff member present. When the office notified the facility that Resident B had arrived without family or staff, the Memory Care Social Service Assistant left the facility to sit with Resident B until a family member arrived. The Memory Care Social Service assistant indicated staff and/or drivers did not typically sign the resident out of the facility for medical appointments and that the LOA sign out forms are typically used for family outings. Interview on 7/9/26 at 1:00 P.M., Facility Transport Driver 2 and Facility Transport Driver 3 indicated a memory care resident should not be left without a staff attendant or family member when being dropped off for an appointment. A review of Resident B's June, 2026 LOA sign out forms on 7/9/26 at 1:15 P.M. included no documentation of the resident being signed out for her appointment on 6/8/26. 2. Record review on 7/8/26 at 2:00 P.M., Resident C's diagnoses included but were not limited to dementia and Guillain-Barre syndrome. The most recent quarterly MDS assessment dated [DATE], indicated the resident had severely impaired cognition. Resident C's care plan included but was not limited to, Resident frequently calls out for help and requests staff assistance to transfer. Upon staff approach and attempt to assist with transfers, resident becomes resistant and may throw self backward into chair or bed, yell out in pain, refuse movement, and verbally protest assistance. Behaviors place resident at an increased risk for falls, injury to self, functional decline, and injury to caregivers (created 5/11/26), Resident is at risk for falls due to: Alzheimer's disease which requires direction and cues from staff, takes 2 or more highfall risk medications, lack of understanding of one's physical and cognitive limitations, impulsive and altered awareness of immediate physical environment (created 6/10/25). Nurses progress notes included, but were not limited to; 6/14/26 at 1:17 P.M., Resident noted to be standing per self while staff were assisting other residents. Resident was trying to transfer self when his legs buckled and resident landed on his knees. Resident C's June & July Medication Administration Record / Treatment Administration Record (MAR/TAR) indicated the resident had routine outside appointments scheduled 6/9/26, 6/10/26, 6/11/26, 7/7/26, 7/8/26, and 7/9/26. The resident's record contained no documentation that included who accompanied the resident to the scheduled outside appointments. Interview and observation on 7/9/26 at 9:15 A.M., Facility Transportation Driver 3 indicated she would be transporting Resident C to his appointment and that Activity Staff 2 would accompany Resident C at the appointment. Facility Transportation Driver 3 indicated she would also accompany residents while at their appointments, at times. Facility Transportation Driver 3 then signed the resident out on the LOA sign out form at the nurse's station and assisted Resident C out of the Memory Care Unit for his outside appointment. Interview on 7/9/26 at 12:00 P.M., the Director of Nursing (DON) indicated Activity Staff 2 was not a CNA or licensed nursing staff. A review of Resident B's June & July, 2026 LOA sign out forms on 7/9/26 at 1:15 P.M. included no documentation of the resident being signed out for his appointment on 6/9/26, 6/10/26, 6/11/26, 7/7/26, or 7/8/26. The resident was signed out by facility staff on 7/9/26. On 7/8/26 at 10:09 A.M., the Facility Administrator supplied a facility policy titled, [Company Name] Facility Bus/Van Transportation Guidelines, dated 12/2025. The policy included, .3. Requirements for resident transportation . g. A nursing assistant or licensed nurse must accompany any resident that has physical, mental, or developmental limitations as determined by the [Interdisciplinary Team] IDT Team .On 7/9/26 at 1:16 P.M., the Facility Administrator supplied a facility policy titled, Leave of Absence (Personal Leave & Medical Appointment), dated 06/2019. The policy included, It is the policy of this facility that continuity of care and safety during resident Leave of Absence will be maintained . 5. The responsible person needs to sign the resident in and out of the facility on the Leave of Absence form prior to exiting the facility and upon return . 6. The licensed nurse will document resident status upon leave from the facility and upon return from leave, and any other pertinent information .This citation relates to intake 3039566.410 IAC 16.2-3.1-45(a)(1)410 IAC 16.2-3.1-45(a)(2)		