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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Compass Park	800 Freemason Parkway Franklin, IN 46131

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38466 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 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., 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. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45292 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. 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 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. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 35099 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)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35099 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 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)