STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Place Health Campus	2200 N Riley Hwy Shelbyville, IN 46176

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34850 Based on interview and record review, the facility failed to ensure interventions to prevent falls were effectively implemented when Resident C exhibited signs and symptoms of lethargy, drowsiness, and sedation and failed to ensure staff used a gait belt during the transfer of a Resident D who required more than limited assistance with transfers for 2 of 3 residents reviewed for falls. This deficient practice resulted in Resident C falling in the shower and sustaining fractures to the left shoulder blade, the left second rib, and the endplate of the third lumbar spinal disc. (Resident C and Resident D) Findings include: 1. The clinical record for Resident C was reviewed on 8/14/24 at 8:30 a.m. The diagnoses included, but were not limited to, dementia, osteoporosis, and insomnia. A quarterly Minimum Data Set (MDS) assessment, dated 5/2/24, indicated Resident C was cognitively impaired. The resident's functional status was dependent of the staff person to provide all the effort for the resident to bathe. The staff was to provide more than half of the effort to assist with transferring in and out of shower. The resident did receive antidepressants and had a history of falling. A care plan, dated 1/16/24, indicated, Resident has impairment in functional status r/t [related to] decreased mobility, weakness, and other comorbidities . A physician order, dated 3/22/24, indicated staff was to monitor Resident C for signs of adverse effects with the usage of hypnotic/sedative/tranquilizer medication. A care plan for fall risk, dated 6/3/24, indicated staff should review the use of a sleep aid medication, change the administration time of a sleep aid medication, encourage activities in common area prior to breakfast, check the resident every two hours during the night shift, encourage resident to sleep in bed at night, use a silent bed alarm on the bed and the recliner, keep wheelchair out of site (sic), offer to get up at 4:00 a.m., utilize a fall mat, utilize a low bed, and staff should assist with transfers as needed. (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 - Actual harm Residents Affected - Few	A psychiatric visit note, dated 6/28/24, indicated, The patient's trazodone was reduced per pharmacy recommendation and she has had significant difficulty with sleeping. We are going to increase trazodone from 75 milligrams to 150 milligrams at HS [night] . A physician order, dated 6/28/24, indicated Resident C was to receive 150 milligrams (mg) of trazodone (antidepressant medication) at night for insomnia. The antidepressant was used as a hypnotic medication. The medication was discontinued on 7/27/24. A psychiatric visit note, dated 7/26/24, indicated resident continued to have problems with sleeping. The plan was to increase current trazodone medication dosage from 150 milligrams to 200 milligrams. A physician order, dated 7/27/24, indicated Resident C was to receive 200 mg of trazodone at night. The medication was discontinued on 7/31/24. The July 2024 Medication Administration Record (MAR) indicated the resident was showing signs and symptoms of side effects with the usage of hypnotic/sedative/tranquilizer medication on the following day and shift: 7/31/24 - evening shift - drowsiness. A nursing note written by Director of Nursing (DON), dated 7/31/24 at 1:43 p.m., indicated the resident was more lethargic, had difficulty staying awake during meals, and the psychiatric care provider was notified. A nursing note, dated 8/1/24 at 6:19 a.m., indicated Psych [psychiatric] services gave ok to reduce Trazodone down to previous dose . A physician order, dated 8/1/24, indicated Resident C was to receive 150 mg of trazodone at bedtime. The August 2024 MAR indicated the following days and shifts the resident was showing signs and symptoms of side effects with the usage of hypnotic/sedative/tranquilizer medication: 8/2/24 - evening shift - extreme drowsiness, 8/3/24 - evening shift - drowsiness, 8/4/24 - day shift - drowsiness and evening shift - sedation. Resident C's clinical record reviewed on 8/14/24, did not include additional safety interventions initiated to address the resident's change of condition. A nursing note, dated 8/4/24 at 1:54 p.m., indicated [Resident C's Representative] in to visit resident, states she has noticed resident is sleeping a lot more lately and would like trazodone held this eve [evening]. A nursing note, dated 8/4/24 at 3:13 p.m., indicated, Resident fell in shower while being assisted with shower by nursing assistant . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A care plan for fall risk, revision date 8/5/24, indicated the resident was to utilize a shower chair during showers. A nursing note by DON, dated 8/6/24, indicated, IDT [Interdisciplinary team] note: Resident has been more lethargic, [Psych Provider 13] increased Trazodone on 7/26. Since reached out to [Psych Provider 13] to let her know that resident was sleeping all day and not tolerating increased dose. Dose was reduced back down to previous dose. Resident continues to be very lethargic and requiring increased assistance with transfers and mobility. Resident had a fall on 8/4, slipped off bench in shower .IDT recommend staff to use shower chair when giving resident a shower. [Resident C Representative] has requested Trazodone be held on 8/4 and 8/5 due to lethargy and not waking to eat meals. Improvement noted in alertness, continues to have difficulty staying awake for long periods of time. Resident did get up and go down for breakfast this morning. Sent email to [Psych Provider 13] to address concerns with Trazodone . A nursing note, dated 8/6/24, indicated, Res [resident] had x-ray done to left arm with results showing a fx [fracture] to left scapula NP [Nurse Practitioner] here and made nursing aware of results. Res cries out in pain when moving res from recliner to w/c [wheelchair] or when touching area of back shoulder. Res sleeps most of the day but is easy to arouse .Writer talked with [representative] and thought sending her out to the ER [emergency room] would be best. Facility transported res via w/c, report called to [name of hospital] ER . An Episodic Event Report for Resident C, completed on 8/8/24, was provided by the Executive Director on 8/13/24 at 9:59 a.m. It indicated, the date of event 8/4/24, Resident slid off shower bench. Fractures to left scapula [shoulder blade], left 2nd rib fracture, L3 [third lumbar spinal disc] endplate fracture [tearing of the cartilage and bone on the top and bottom of each disc in back] . A nursing progress note, dated 8/11/24, indicated, Resident returned to facility from hospital on 8/9/24 . A statement by Certified Resident Care Assistant (CRCA) 6, dated 8/5/24, indicated the following, .I was taking her to the shower and placed her on the shower bench. I went to warm up the water and had it spraying in the corner. While she was sitting there with the water running, she started to lean or slide off the bench and I attempted to keep her from falling. But she continued to fall to her side . An interview was conducted with the Occupational Program Director on 8/14/24 at 10:39 a.m. She indicated Resident C was a single staff person transfer. The staff utilizing a shower bench or shower chair was fine. The resident could tolerate either one. Prior to the resident fall, it was safe to place her on the shower bench. An interview was conducted with CRCA 6 on 8/14/24 at 1:37 p.m. She indicated, on 8/4/24, Resident C was not drowsy or lethargic that day. CRCA 6 often placed the resident on the shower bench during showers. The resident was able to tolerate sitting on the bench on previous shower days, so she continued to sit the resident on the bench during bathing. She does get report from previous shifts of the condition of the residents for example: when the resident was last toileted and if they are out of the building. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Trazodone medication at MedlinePlus drug information at website www.medlineplus.gov, dated 1/15/22, was retrieved on 8/19/24. The website indicated the following, .Trazodone is used to treat depression. Trazodone is in a class of medications called serotonin modulators. It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance .Trazodone is also sometimes used to treat insomnia .Trazodone may cause side effects .weakness or tiredness .dizziness or lightheadedness 2. The clinical record for Resident D was reviewed on 8/14/24 at 9:20 a.m. The diagnoses included, but were not limited to, stroke and muscle weakness. An annual MDS assessment, dated 7/24/24, indicated Resident D was cognitively intact. The resident's functional status was dependent of the staff person to provide all the effort for the resident to go from a sitting position to a stand position. The staff person was to assist over half of the effort when a resident needed to be transferred from a chair to wheelchair. The risk of falling care plan, dated 9/28/21, indicated, Resident is at risk for falling r/t [related to]: dx [diagnosis] of acute encephalopathy [brain disease], CVA [stroke], weakness, decreased mobility, medication regimen, requires assistance with transfers, incontinent status, pain, and other comorbidities .Encourage resident to assume standing position slowly, Ensure the floor is free of liquids and foreign objects, Keep call light in reach, Encourage to assume standing position slowly, Keep personal items and frequently used items within reach, Provide non-skid footwear . A nursing note written by Registered Nurse (RN) 5, dated 7/26/24, indicated, Res [resident] was being transferred to recliner and was dropped. No sign of injury . A nursing note written by the DON, dated 8/2/24, indicated, .fall on 7/26, staff was assisting resident from recliner to w/c [wheelchair] to go to the bathroom when the CRCA [Certified Resident Care Assistant 6] had difficulty with transfer causing resident to fall. No injuries noted. Resident just startled from fall. IDT [Interdisciplinary team] recommends gait belt with transfers. Resident remains an assist of 1 [one] with [Activities of Daily Living] ADL's and transfers. Able to make needs and wants known. Resident able to ambulate short distance with walker and uses w/c for long distance . An event report, dated 7/26/24, indicated Resident D had a witnessed fall in her room while ambulating with assistance. The resident requires assistance to transfer. The risk of falling care plan, with a revision date 8/6/24, indicated a new intervention, start date of 7/31/24, for the staff to utilize a gait belt when transferring the resident. A typed statement for CRCA 6, dated 7/26/24, indicated the following, Resident [D] needed to use the restroom, so I went to help her transfer. Resident was in her recliner, and I went to assist her into her wheelchair. During the transfer the resident was unsteady, so I lowered her to the floor . An interview was conducted with Physical Therapist 3 and Occupational Program Director on 8/14/24 at 10:32 a.m. They indicated they recommend staff to utilize gait belts for all resident transfers. An interview was conducted with CRCA 4 on 8/14/24 at 11:59 a.m. She indicated gait belts were to be utilized to assist with resident transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Resident D on 8/14/24 at 1:25 p.m. She indicated she had fallen. She stood up from her recliner to be transferred to her wheelchair. The staff person was too little to transfer me, and lowered her to the floor. She was not hurt. An interview was conducted with RN 6 on 8/14/24 at 1:50 p.m. She indicated she would assume that staff should use gait belts to transfer residents. An interview was conducted with CRCA 6 on 8/14/24 at 1:37 p.m. She indicated she was the staff person that was assisting Resident D with a transfer, on 7/26/24, when she had fallen. She did not utilize a gait belt to assist while transferring the resident at the time of the fall. Staff are required to use gait belts for some residents, but not all. An interview was conducted with the DON on 8/14/24 at 1:55 p.m. She indicated it was optional for staff to utilize gait belts to assist with transferring a resident unless the resident was care planned for gait belt use. A fall management program guidelines policy, revised 5/31/17, was provided by the Executive Director (ED) on 8/13/24 at 9:30 a.m. The policy indicated, .PURPOSE .strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures .intensive efforts will be directed toward minimizing or preventing injury .PROCEDURES .b. Care plan interventions should be implemented that address the resident's risk factors .2 .This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possibly contributing factors, interventions to reduce the risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions .5. The resident care plan should be updated to reflect any new or change in interventions A gait belt policy was provided by the Executive Director on 8/14/24 at 1:20 p.m. The policy indicated, . Purpose .To ensure safety for the resident and staff during transfers and mobility activities. Procedures . 1. Gait belts should be used according to the plan of care for the individual resident. 2. If resident requires use of gait belt, add to resident plan of care that will be communicated to the caregiver. 3. If a resident requires more than limited assists and does not require a lift a gait belt may be used with transfers. 4. An individual campus may designate a gait belt be used during all mobility activities. 5. Gait belts will be provided by the campus and should remain in the campus at all times for use by all staff during transfers. 6. Campus should have various sizes of gait belts available. 7. Failure to use a gait belt as defined in the resident plan of care or as designated by campus protocol may lead to disciplinary action up to and including termination. The Indiana State Department of Health Nurse Aide Curriculum, revised November 19, 2015, indicated the following, .PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION .3. Place belt around resident's waist with the buckle in front and adjust to a snug fit ensuring that you can get your hands under the belt .4. Assist the resident to stand on count of three .6. Stand to side and slightly behind resident while continuing to hold onto belt .PROCEDURE #26: TRANSFER TO WHEELCHAIR .2. Place wheelchair on resident's unaffected side .4. Stand in front of resident and apply gait belt around the resident's abdomen . This citation is related to Complaints IN00440513 and IN00440297. 3.1-45(a)(1) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3.1-45(a)(2)