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	08/13/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) assessment for alarm use for 2 of 2 residents reviewed for falls. (Resident 17 and Resident 25)Findings include: 1. The clinical record for Resident 17 was reviewed on 8/11/25 at 11:30 a.m. The diagnoses included, but were not limited to, dementia. A fall care plan, dated 1/16/24, indicated Resident (17) is at risk for falling r/t [related to] decreased mobility, medication regimen, weakness, incontinent status and other comorbidities. The interventions included but were not limited to: the resident's usage of a clip alarm when in wc/chair [wheelchair] with a start date of 3/6/25, and usage of a floor mat alarm when in recliner with a start date of 11/14/24. A physician's order, dated 3/5/25, indicated Resident 17 was to wear a personal pull tab alarm while in the wheelchair every shift. A physician's order, dated 5/21/25, indicated Resident 17 was to have a floor mat alarm in place every shift. The 7/7/25 Quarterly MDS assessment for Resident 17 indicated the resident did not use alarms. An interview was conducted with the MDS Coordinator on 8/12/25 at 3:14 p.m. She indicated the Quarterly July 2025 MDS assessment for Resident 17 was coded incorrectly. The resident was using alarms. The assessment was going to be modified and corrected. 2. The clinical record for Resident 25 was reviewed on 8/8/25 at 10:40 a.m. The diagnoses included, but were not limited to, Parkinson's disease and traumatic brain injury. A physician's order, dated 6/10/25, indicated he was to have a pressure alarm at all times. The pressure alarm was to be moved from the wheelchair to the recliner or bed with the resident. A Quarterly MDS assessment, completed 7/9/25, indicated bed and/or chair alarms had not been used during the assessment period. During an interview on 8/12/25 at 3:14 p.m., the MDS Coordinator indicated the bed and chair alarm should have been coded on the Quarterly MDS completed on 7/9/25. The facility used the Resident Assessment Instrument Manual as the policy for completing the MDS assessments.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to timely refer a resident for a level II evaluation for 1 of 1 resident reviewed for Preadmission Screening and Resident Review (PASRR). (Resident 19)Findings include: The clinical record for Resident 19 was reviewed on 8/8/25 at 3:17 p.m. The diagnoses included, but were not limited to, diabetes and psychotic disorder with delusions. A PASRR Level I evaluation, dated 8/10/23, indicated Resident 19 was approved with no Level II required. On 6/1/24, Resident 19 received a new diagnosis of psychotic disorder with delusions. During an interview on 8/8/25 at 2:59 p.m., the Executive Director (ED) indicated Resident 19 did not have a Level II. During an interview on 8/11/25 at 2:35 p.m., the Social Services Director (SSD) indicated Resident 19 should have been referred for a Level II with the new diagnosis of psychosis. On 8/11/25 at 11:29 a.m., the Nurse Consultant (NC) provided the current Indiana PASRR Standard Operating Procedure, which indicated .Overview Preadmission Screening and Resident Review [PASRR] is a federal requirement to help ensure that individuals are appropriately placed in nursing facilities for long-term care .Change in status and Level II follow up Social Services ensures paperwork is submitted. They will print out the outcome letter and upload to Matrix file .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure an insulin flex pen was primed prior to dialing up the dosage to be given when administering insulin per the manufacture directions for 1 of 2 residents observed during insulin administration. (Resident 8)Findings include: The clinical record for Resident 8 was reviewed on 8/8/25 at 2:00 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.A diabetic care plan, dated 7/1/25, indicated the staff was to administer the medication as ordered. A physician's order, dated 6/16/25, indicated Resident 8 was to receive 10 units of lispro insulin (fast acting insulin) with a flex pen before meals. An observation was conducted of an insulin administration for Resident 8 with Licensed Practical Nurse (LPN) 3 on 8/8/25 at 11:03 a.m. LPN 3 was observed obtaining the resident's blood sugar reading of 273. After, she prepared to administer 10 units of lispro insulin using an insulin flex pen. During that time, LPN 3 wiped the flex pen with an alcohol wipe and placed the needle on the pen. She then dialed up 10 units of insulin and administered the insulin to the resident. LPN 3 was not observed priming the insulin flex pen prior to the administration of the 10 units of lispro insulin. An interview was conducted with the Director of Nursing Services (DNS) on 8/12/25 at 2:01 p.m. She indicated the insulin flex pens were to be primed prior to the administration of the insulin dosage.Instructions for use insulin Lispro manufacture instructions at website www.//pi.lilly.com ,dated 12/2023, was retrieved on 8/13/25. It indicated .Prescribing information .Priming your pen Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding the pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. 3.1-37(a)

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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. Based on observation, interview, and record review, the facility failed to ensure a gait belt was used during the manual transfer of a resident and to ensure an evaluation was conducted timely for the usage of personal alarms for 2 of 2 residents reviewed for accidents. (Resident 17 and Resident 25) Findings include: 1a. The clinical record for Resident 25 was reviewed on 8/8/25 at 10:40 a.m. The diagnoses included, but were not limited to, Parkinson's disease and traumatic brain injury. A physician's order, dated 3/23/25, indicated he was to have a pressure alarm in his wheelchair at all times. This order was discontinued on 5/23/25. A physician's order, dated 5/23/25, indicated he was to have a pressure alarm to his wheelchair and recliner when he was present. This order was discontinued on 6/10/25. A physician's order, dated 6/10/25, indicated that he was to have a pressure alarm at all times, ensure pressure alarm was moved from wheelchair to recliner and bed with him. A Quarterly Minimum Data Set (MDS) assessment, completed 7/9/25, indicated he was dependent on staff for chair to bed transfers and to go from a sitting to a standing position. He had fallen one time, with no injury, since his last MDS assessment. A care plan, last reviewed and revised on 8/7/25, indicated Resident 25 was at risk for falling related to decreased mobility, weakness, Parkinson's disease, subdural hematoma (pool of blood between the brain and its outermost covering), and orthostatic hypotension (blood pressure drops when standing up). The goal was for him to remain free of falls with major injury. The interventions included, but were not limited to, pressure alarm at all times, scoop mattress on his bed, and mattress next to the bed at bedtime. An Alarm and Restrictive Device Evaluation, dated 8/7/25, indicated Resident 25 had a chair and bed alarm. The alarms were being used to identify patterns or routines. There were no other Alarm and Restrictive Device Evaluations present in the clinical record. During an interview on 8/12/25 at 3:37 p.m., the Nurse Consultant (NC) and the Director of Nursing Services (DNS) indicated the alarm evaluations for the usage of the sounding alarms should have been completed when the pressure alarm was initiated. 1b. During an observation on 8/8/25 at 10:24 a.m., Resident 25 was sitting in a recliner in the common area, two Certified Resident Care Associates (CRCAs) approached Resident 25 with his wheelchair. The two CRCA's manually transferred Resident 25 from the recliner chair to his wheelchair by lifting Resident 25 under the arms and holding the back of his pants. A gait belt was not used. The pressure alarm sounded and was silenced by another staff member. The pressure alarm was placed in the wheelchair prior to the CRCAs sitting Resident 25 down in the wheelchair. During an interview on 8/12/25 at 1:32 p.m., the Therapy Director (TD) indicated Resident 25 required two staff members and a gait belt to transfer. A gait belt should be utilized. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/11/25 at 2:30 p.m., the NC provided the Guidelines for Gait Belt Use, last reviewed 12/17/24, that indicated .The purpose of this policy is to: To ensure safety for the resident and staff during transfers and mobility activities. 2. The clinical record for Resident 17 was reviewed on 8/11/25 at 11:30 a.m. The diagnoses included, but were not limited to, dementia. A fall care plan, dated 1/16/24, indicated Resident (17) is at risk for falling r/t [related to] decreased mobility, medication regimen, weakness, incontinent status and other comorbidities. The interventions included but were not limited to, the resident's usage of a clip alarm when in wc/chair [wheelchair] with a start date of 3/6/25, and usage of a floor mat alarm when in recliner with a start date of 11/14/24. A progress note, dated 11/1/24, indicated .Was up in wheelchair for couple of hours today and went to therapy. Alarm in place and working well will continue to monitor an assist as needed. A physician's order, dated 3/5/25, indicated Resident 17 was to wear personal pull tab alarm while in wheelchair every shift. A physician's order, dated 5/21/25, indicated Resident 17 was to have floor mat alarm in place every shift. An alarm and restrictive evaluation, dated 8/7/25, indicated the resident was in use of alarms for bed, chair, floor, and clipped alarm. An interview was conducted with the Nurse Consultant and the DNS on 8/12/25 at 3:37 p.m. The DNS indicated Resident 17 started using the sound alarms in November 2024. The resident currently was in use of a chair and a floor mat alarm. The alarm evaluations for the usage of the sounding alarms should have been completed in November. The Guidelines for Position Change Alarms policy was provided by the DNS on 8/11/25 at 11:29 a.m. It indicated, .The purpose of this policy is to: To ensure completion of observation and evaluation for appropriate use of positioning alarms for each resident.Procedure. 1. Types of position change alarms include chair and bed silent alarm sensor, and motion alarm detectors. Alarm should also be evaluated to determine if device is a restraint or enabler.3. A restraint/enabler event and associated observations should be completed, in the resident's EHR [electronic health record], upon initiating a positioning alarm. 3.1-45(a)(1) 3.1-45(a)(2)

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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. Based on observation, interview, and record review, the facility failed to ensure infection control was maintained by not disinfecting a glucometer (a device used to obtain blood sugar readings) per the manufacturer's instructions for 1 of 2 residents observed during medication administrations of blood sugar readings. (Resident 43)Findings include: The clinical record for Resident 43 was reviewed on 8/8/25 at 2:30 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.A physician's order, dated 7/22/25, indicated Resident 43 was to receive nine units of Novolog (fast acting) insulin before meals. If the resident's blood sugar reading was less than 100; hold the insulin. An observation was conducted of obtaining Resident 43's blood sugar reading with Licensed Practical Nurse (LPN) 3 on 8/8/25 at 11:17 a.m. LPN 3 was observed removing the glucometer from the medication cart. She then wiped the glucometer utilizing an alcohol wipe. She then went to the resident's room. LPN 3 was observed pricking the resident's finger, placing a drop of blood from the resident's finger onto the test strip inserted in the glucometer device to obtain the reading. After, she left the resident's room and returned the glucometer into the medication cart. There was no disinfecting the glucometer after the resident's blood sugar was obtained. An interview was conducted with LPN 3 on 8/8/25 at 11:56 a.m. She indicated she had used the wrong wipes to disinfect the glucometer before and after use. Alcohol wipes were not to be used to disinfect the glucometer. At that time, she provided the germicidal bleach wipes the staff were to use to disinfect the glucometers. The manufacturer's instructions of the glucometer were provided by the Director of Nursing Services on 8/12/25 at 2:06 p.m. It indicated, .Cleaning and Disinfecting.2. Open the cap of the Clorox Germicidal Wipes Container, pull out 1 towelette and close the cap. 3. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids.5. Pull out 1 new towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-borne pathogens. 3.1-18(b)(1)