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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/14/2024 |
| NAME OF PROVIDER OR SUPPLIER Aspen Place Health Campus | | STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N Montgomery Road Greensburg, IN 47240 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>34232</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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 medications.</p> <p>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 .</p> <p>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 .</p> <p>3.1-11(a)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38769</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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 [DATE]:</p> <ul style="list-style-type: none"> - 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. <p>The resident had 6 out of 10 showers, complete bed baths, or refusals from admission to discharge on 04/08/24.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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:</p> <ul style="list-style-type: none"> - 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. <p>The resident was given or offered a bath or shower 11 of 15 times from 03/07/24 through 04/30/24.</p> <p>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 .</p> <p>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 .</p> <p>This citation relates to Complaint IN00435626.</p> <p>3.1-38(a)(2)(A)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>34232</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 their room, the CNA indicated the urinary catheter bag and tubing should not be touching the floor.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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 Clorpectin (an antibacterial agent) flush, 60 ml (milliliters) infused in the bladder and clamped for 15 minutes.</p> <p>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 .</p> <p>3.1-41(a)(2)</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>38769</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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 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.</p> <p>The resident's hospital discharge weight was 177 pounds.</p> <p>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.</p> <p>The resident had the following weights documented while in the facility:</p> <ul style="list-style-type: none"> - 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. <p>(continued on next page)</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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 hospital discharge weight.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>This citation relates to Complaint IN00435626.</p> <p>3.1-46(a)(1)</p> <p>3.1-46(a)(2)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>38239</p> <p>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.</p> <p>Findings include:</p> <p>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:</p> <ul style="list-style-type: none"> - A Lispro insulin pen for Resident 28. The pen was well over 3/4 full and was not labeled with an opened on date. <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> - An opened box that contained a nearly empty vial of TB (Tuberculin) serum. The vial was not labeled with an opened on date. <p>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.</p> <p>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.</p> <p>Resident records reviewed indicated the following residents' TB tests were performed using the unlabeled vial of TB serum:</p> <ul style="list-style-type: none"> - 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. <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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 .</p> <p>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 .</p> <p>3.1-25(o)</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38769</p> <p>Based on observation and interview, the facility failed to store food appropriately for 1 of 2 kitchen observations.</p> <p>Findings include:</p> <p>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:</p> <ul style="list-style-type: none"> - 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. <p>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.</p> <p>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 .</p> <p>3.1-21(i)(3)</p> | | |