STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155821	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASPEN TRACE HEALTH & LIVING COMMUNITY	3154 SOUTH STATE ROAD 135 GREENWOOD, IN 46143

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00412739. This visit was in conjunction with a Recertification and State Licensure Survey, State Residential Licensure Survey, and the Investigation of Complaints IN00408001 and IN00408578. Complaint IN00412739 - Federal/State deficiencies related to allegations are cited at F656. Complaint IN00408001 - No deficiencies related to the allegations are cited. Complaint IN00408578 - No deficiencies related to the allegations are cited. Survey dates: July 5, 6, 7, 10, 11, 12, 13, and 14, 2023 Facility number: 013185 Provider number: 155821 AIM number: 201221460 Census Bed Type: SNF: 44 SNF/NF: 53 Residential: 57 Total: 154 Census Payor Type: Medicare: 11 Medicaid: 41 Other: 45 Total: 97	F 0000	**This plan of correction is to serve as Aspen Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Aspen Trace or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to respectfully request paper compliance for Aspen Trace's Complaint Survey.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Carnes		07/25/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 19, 2023.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.			

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	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to follow the plan of care for 1 of 4 residents reviewed for medication administration. Physician's orders were not followed. (Resident B) Finding includes: During an observation on 7/6/23 at 8:55 a.m., Registered Nurse (RN) 3 was observed preparing Resident B's medications with the DON present. When RN 3 got to the order for the dabigatran etexilate (Pradaxa) medication, RN 3 indicated that the medication was not available and that it had been reordered from the pharmacy. Neither staff member knew the generic name for the medication. During an interview on 7/6/23 at 1:57 p.m., the Administrator and the DON indicated that the medication had not been recognized by the generic name by staff administering medications and staff were unaware it was in the medication cart. They indicated Resident B had received it intermittently and should have received it twice daily as ordered.	F 0656	**F656 Develop/Implement Comprehensive Care Plan** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident B no longer resides in facility. At the time of the alleged deficient practice Resident B's plan of care was updated to ensure prescribed medications would be administered to the resident. **II. The facility will identify other residents that may potentially be affected by the practice.** An audit of all medication orders compared to the medication draws was completed to identify if any other residents were affected by	07/28/2023

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	During an observation with the Administrator on 7/6/23 at 3:15 p.m., Resident B's dabigatran etexilate (Pradaxa) medication was observed in the bottom drawer of the medication cart containing Resident B's other medications. The label indicated that the pharmacy had sent the medication to the facility on 6/27/23. On 7/7/23 at 9:15 a.m., Resident B's clinical record was reviewed. Resident B's diagnoses included, but were not limited to, paroxysmal atrial fibrillation (a rapid, erratic heart rate that starts and stops on its own), chronic diastolic congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should), chronic kidney disease, and the presence of a cardiac pacemaker. Physician orders included, and were not limited to: - Dabigatran etexilate (Pradaxa, a blood thinner or anticoagulant medication) capsule; 75 mg (milligrams) 1 capsule, oral twice a day for paroxysmal atrial fibrillation with a start date of 6/26/23 and no stop date noted. Resident B's electronic medication administration record (eMAR) from 6/26/23 through 7/6/23 was reviewed and indicated that the following: - On 6/27/23 for the "Upon Rising" (7:00 a.m. - 11:00 a.m.) dose, the medication was marked as not administered; the reason was "On Hold" and the comment was "awaiting pharmacy". - On 6/27/23 for the "Before Bedtime" (6:00 p.m. - 10:00 p.m.) dose, the medication was marked as not administered; the reason was "Other", and the comment was "pending pharm".		the alleged deficient practice. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** -Education will be provided to licensed nurses and QMA's regarding the facility's policy on developing/implementing comprehensive care plan. -A LifeSpan Pharmacy Tech audited med carts in the facility and ensured orders matched the medication in the med cart. Any discrepancies that were identified were immediately corrected. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON/Designee will audit, see attachment A for audit tool, 5 random resident's clinical chart per week to ensure the plan of care is being followed for 4 weeks, if any discrepancies are identified it will be addressed and corrected immediately: then, monthly thereafter totaling 12 months of monitoring. **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and**	

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	- On 6/28/23 for the "Upon Rising" dose, the medication was marked as not administered; the reason was "Other", and the comment was "waiting on rx [prescription]". - On 6/29/23 for the "Upon Rising" dose, the medication was marked as not administered; the reason was "Drug/Item Unavailable", and the comment was "pharmacy notified, waiting on delivery". - On 6/30/23 for the "Upon Rising" dose, the medication was marked as not administered; the reason was "Drug/Item Unavailable", and the comment was "pharmacy has been notified". - On 7/1/23 for the "Upon Rising" dose, the medication was marked as not administered; the reason was "Drug/Item Unavailable". The entry lacked an associated comment. - On 7/2/23 for the "Upon Rising" dose, the medication was marked as not administered; the reason was "On Hold" and the comment was "awaiting arrival". - On 7/3/23 for the "Upon Rising" dose, the medication was marked as not administered; the reason was "On Hold" and the comment was "awaiting pharmacy". - On 7/5/23 for the "Upon Rising" dose, the medication was marked as not administered; the reason was "Drug/Item Unavailable", and the reason was "medication reordered". - On 7/5/23 for the "Before Bedtime" dose, the medication was marked as not administered; the reason was "Drug/Item Unavailable". The entry		**duration of reviews will be adjusted as needed.** **V. Plan of Correction completion date.** Date of Compliance: 7/28/2023 The Administrator will be responsible for ensuring the facility complies by date of compliance listed.	

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	lacked an associated comment. On 7/10/23 at 8:50 a.m., the DON provided a copy of the Protocol for Following Physician Orders, dated for 4/3/17, and indicated it was the policy currently in use by the facility. A review of the policy indicated under the procedure portion, "All licensed staff will verify and follow physician orders as written. If for any reason, the physician order cannot be followed, the professional will contact the physician for further instructions." This Federal tag relates to Complaint IN00412739. 3.1-35(g)(2)			