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	12/30/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00397556 and IN00397603. Complaint IN00397556 - Substantiated. Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00397603 - Substantiated. No deficiencies cited related to allegations are cited. Survey dates: December 29 and 30, 2022 Facility number: 013185 Provider number: 155821 AIM number: 201221460 Census Bed Type: SNF/NF: 90 Residential: 57 Total: 147 Census Payor Type: Medicare: 15 Medicaid: 40 Other: 35 Total: 90 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 3, 2023.	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.**	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Carnes		01/12/2023

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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	(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard			

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	medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure a medical record were complete for 1 of 3 residents reviewed for medical records. (Resident B) Finding includes: During an interview on 12/29/22 at 2:07 p.m., Resident B indicated she was sent to the hospital a few weeks ago but she didn't remember why. The clinical record for Resident B was reviewed on 12/30/22 at 8:31 a.m. The diagnosis included, but was not limited to, anxiety disorder.	F 0842	**I.** Resident B still resides in the facility. Education provided to licensed nurses and QMA's that were on duty during resident's transfer on 10/7/2022. **II.** Other residents have the potential to be affected by the alleged deficient practice. Other residents that have been sent to the hospital within the last 3 months have been reviewed to determine if information was documented regarding transfer to the hospital. Any discrepancies	01/18/2023

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	A Quarterly MDS (Minimum Data Set) assessment, dated 9/22/22, indicated Resident B was cognitively intact. A hospital discharge summary, dated 10/7/22, indicated Resident B was sent to the emergency department and diagnosed with aspiration and pneumonia. The clinical record lacked information related to Resident B's transfer to the hospital. During an interview on 12/30/22 at 12:19 p.m., the DON (Director of Nursing) indicated Resident B was sent to the emergency department on 10/7/22. The staff should have documented when Resident B was sent to the hospital. On 12/30/22 at 10:00 a.m., the DON provided a copy of a facility policy, titled Change in a Resident's Condition or Status, dated 10/2010, and indicated this was the current policy used by the facility. A review of the policy indicated the nurse supervisor/charge nurse with record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. This Federal tag relates to Complaint IN00397556. 3.1-50(a)(1)		that were identified were immediately corrected. **III.** Education will be provided to licensed nurses and QMA's regarding the facility's policy on Resident's Condition or Status. **IV.** The DON/Designee will audit, see attachment B for audit tool, 5 random resident's clinical chart per week to ensure proper documentation on transfers is in each resident's chart for 4 weeks, if any discrepancies are identified 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 duration of reviews will be adjusted as needed** **V. Plan of Correction completion date.** Date of Compliance: 1/18/2023 The Administrator will be responsible for ensuring the facility complies by date of compliance listed.	