

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 17, 18, 19, 20, and 21, 2011</p> <p>Facility number: 000148 Provider number: 155526 AIM number: 100275500</p> <p>Survey team: Karen Lewis, RN, TC Delinda Easterly, RN Betty Retherford, RN Ginger McNamee, RN</p> <p>Census bed type: SNF/NF: 83 Total: 83</p> <p>Census payor type: Medicare: 8 Other: 75 Total: 83</p> <p>Stage 2 Sample: 33</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged in the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------------	--	---------------------	--	----------------------------

	Quality review completed on October 26, 2011 by Bev Faulkner, RN			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0156 SS=B	<p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents were provided detailed information as to why Medicare coverage was being terminated for 3 of 3 residents reviewed who had received notification of Medicare non-coverage. (Resident #'s 51, 52, 58)</p> <p>Findings include:</p> <p>1.) Review of the "Notice of Exclusions from Medicare Benefits" letters for Resident #'s 51, 52, and 58 on 10/20/11 at 3:40 p.m., indicated the letters lacked detailed information as to why Medicare coverage was being terminated.</p> <p>During an interview with the Business Office Manger on 10/20/11 at 1:45 p.m., she indicated she was unaware</p>	F0156	<p><b>F 156</b></p> <p><b>Corrective Action for Affected Residents:</b> Please note that residents #51, #52, and #58 received notices with information as to why Medicare coverage was terminated.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents whose Medicare coverage is terminated could be affected, the following corrective actions shall be taken:</p> <p><b>Measures to Ensure Practice does not Recur:</b> Facility representatives responsible for the issuance of coverage notices have been addressed as to proper procedure, including completion of said notices prior to delivering to the applicable resident.</p> <p><b>This Corrective Action will be</b></p>	11/08/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>the Medicare letters needed to have detailed information as to why the coverage was being terminated.</p> <p>3.1-4(f)(3)</p>		<p><b>Monitored by:</b> As a means of quality assurance, each notice issued will be provided to the Administrator for review prior to delivery to the resident in an effort to confirm continued compliance with provision of sufficient detailed information as to why the Medicare coverage is being terminated. (See Attachment D) These reviews will be discussed at the quarterly QA committee for a minimum of 6 months at which the need for continued monitoring will be adjusted accordingly.</p> <p><b>Date of Completion:</b> 11/8/11</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0241 SS=E	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to answer a call light timely resulting in abdominal pain and crying for 1 resident [Resident #104] in a Stage 2 Sample of 33 and failed to remove 2 residents in a Stage 2 Sample of 33 from the dining room, after the evening meal, prior to cleaning the dining room and dimming the lights. [Resident #'s 104 and #20]</p> <p>Findings include:</p> <p>1. Resident 104's clinical record was reviewed on 10/20/11 at 9:30 a.m. The resident was admitted to the facility on 10/10/11 for respite care while her care giver was in the hospital.</p> <p>The resident's diagnoses included, but were not limited to, arthritis and restless leg syndrome.</p> <p>Resident #104 had a 10/11/11, care plan problem of the resident requires the assistance of two with ADL's [Activities of Daily Living] as follows: bed mobility; transfer; ambulation; mobility; toileting; bathing; and</p>	F0241	<p><b>F 241</b> An Informal Dispute Resolution is being requested. <b>Corrective Action for Affected Residents:</b> Resident #104 denies any further abdominal pain or crying occurrences related to call light response times. Resident's #104 &amp; #20 deny any further occurrences with being left in the dining room after meals. <b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, the following corrective actions shall be taken: <b>Measures to Ensure Practice does not Recur:</b> Nursing staff was in-serviced on 10/31/2011 in regards to call light policy and procedure, peri-care, A.M and P.M. care, toileting, and dignity. All policy and procedures listed above were reviewed with no changes indicated at this time. <b>This Corrective Action will be Monitored by:</b> D.O.N/Designee to monitor call light response times (See Attachment E) and resident care (See Attachment F) on 5 residents daily on scheduled work days on varying shifts times 4 weeks, then 5 residents weekly times 4 weeks, then 5 residents monthly to ensure continued compliance. Should concerns be</p>	11/08/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>dressings due to arthritis and limited mobility. It indicated she needed the she assistance of one for grooming.</p> <p>During an interview with Resident #20's family members on 10/18/11 at 1:15 p.m., they indicated they had observed Resident #104 crying and complaining of abdominal pain on 10/16/11. They indicated they were visiting with Resident #104's roommate [Resident #20] at the time. They indicated Resident #104 had turned on her call light. The family members indicated Resident #104 was watching the door and told them she observed two CNA's walking together past her door without acknowledging the call light two separate times while waiting to go to the bathroom.</p> <p>Resident #104 was interviewed on 10/19/11 at 8:51 a.m. The Resident was alert and oriented to person, place, and time and was able to answer screening questions appropriately for care and services provided. Resident #104 indicated on Sunday [10/16/11] around 4:00 p.m., she had to go to the bathroom and had turned on the call light and no one would come. She indicated her roommate's family were present and had tried to find staff to help her, but</p>		<p>identified, immediate corrective action shall be taken, including re-education, as warranted. A report of progress will be forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted. <b>Date of Completion:</b> 11/8/11</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>they could not find any. She indicated she had seen two staff members walk pass the door two different times and not come in. She stated "I was crying because I had to go to the bathroom and it made my stomach hurt. I have had two bladder surgeries and was told I was going to have problems holding my urine the rest of my life."</p> <p>The resident indicated she has been at the facility for less than two weeks and does not recognize staff by name yet. She indicated she and her roommate [Resident #20] sit at the same table in the dining room during meals. She indicated after one evening meal the staff removed all of the residents from the dining room except herself and Resident #20. She indicated the dirty dishes were removed, the tables and floors were cleaned, the lights were dimmed, and the staff left the dining room. She indicated she and Resident #20 were left in the dining room. She indicated sitting in her wheelchair for very long causes her knees and legs to hurt.</p> <p>She stated "I only get washed up on shower days. I don't get my face or hands washed any other time. I went from Saturday's shower until yesterday [Tuesday] without having</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>my face and hands washed. I would like to have them washed more. They don't wash up my roommate either. They take her [Resident #20] to the bathroom and shake powder down her but don't wash her. They sometimes leave the bathroom door open and I can see what they do or they bump the door and it comes open and I can see in the bathroom."</p> <p>During a 10/20/11, 8:30 a.m., interview with the Director of Nursing, she indicated the walkie talkies had been down for a few months and the facility had just resumed using them within the last week to ten days. She indicated staff is to answer the call lights and if they can't complete the task they should use the walkie talkie to let another staff member know what the resident needs. She indicated the call light should not be turned off until the staff are ready to meet the resident's request. She indicated residents should receive a.m. and p.m. care.</p> <p>2. Resident #20's clinical record was reviewed on 10/20/11 at 9:57 a.m. The resident's diagnoses included, but were not limited to, depression; altered mental status; psychosis secondary to dementia; Parkinson's disease; arthritis; urinary frequency;</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>schizoaffective disorder with delusions and agitation; anxiety; Alzheimer's disease with delusions; and dementia.</p> <p>The resident had a 9/16/11, annual Minimum Data Set Assessment. The assessment indicated the resident required the extensive assistance of two or more persons for all activities of daily living except eating.</p> <p>An observation of Resident #20 was made on 10/19/11 at 11:32 a.m. The resident had dried brown stains on the fingers of her right hand. Three CNA's ambulated the resident to the bathroom. The Assistant Director of Nursing was also present. The resident smelled of urine and her pants were wet in the front and back. The resident's privacy curtain was not closed and the bathroom door was left open. The resident's roommate had full view of the resident in the bathroom with her pants down. CNA #1 indicated the brown stains on the resident's right hand was from the hot chocolate the resident had at breakfast. The CNA indicated the resident sticks her fingers in her hot chocolate to test the temperature before drinking it.</p> <p>The Resident Council Minutes on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>10/10/11, indicated Resident #104 was being left in the dining room for long period after meals.</p> <p>During an interview with two of Resident #20's family members on 10/18/11 at 1:15 p.m., they indicated they frequently found the resident in her room at meal time and her tray was on the table in the dining room. They indicated she is left behind before and after meals. They indicated at least one of them visit the resident everyday at random times. They indicated they frequently found the resident's call light out of her reach and they had went and got the Administrator to show her the resident could not reach the call light. They indicated the resident was not receiving a.m. and p.m. care.</p> <p>During an interview with the resident's roommate [Resident #104] on 10/19/11 at 8:51 a.m., she indicated the staff did not perform a.m. and p.m. care on Resident #20. She indicated the staff frequently leave the bathroom door open and she can see they just use powder and do not wash Resident #20. She indicated the staff just get them dressed of a morning and night.</p> <p>During an interview with the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>Administrator on 10/20/11 at 3:12 p.m., she indicated Resident #20's family had shown her Resident #20's call light was not in reach. She indicated the family had voiced concerns of the resident not being taken and or removed from dining room.</p> <p>The current 9/05, "Call Light Procedure" was provided by the Nurse Consultant on 10/20/11 at 3:39 p.m. The policy indicated the purpose was to allow the resident to request assistance when needed. The procedure indicated the call light should be within reach of the resident at all times and answered promptly.</p> <p>The current 9/05, "Bedtime Care Procedure" was provided by the Nurse Consultant on 10/20/11 at 3:39 p.m. The purpose of the procedure was to prepare the resident for night. The procedure indicated the resident was to be assisted with washing their hands, face, and perineal area.</p> <p>The current July, 1998, "Core Curriculum" for the Indiana State Department of Health Nurse Aide Training Program, indicates in Procedure 30 that CNA's should wash residents' hands after meals to promote dignity.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	3.1-3(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0244 SS=E	<p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on record review and interview, the facility failed to act upon grievances identified during Resident Council meetings to ensure issues were promptly resolved for 3 of 4 Resident Council Minutes reviewed.</p> <p>Findings include:</p> <p>On 10/20/11 at 10:30 a.m., with permission from the Resident Council president, the Resident Council Minutes for the months of July, 2011 through September, 2011, were reviewed.</p> <p>Review of the Resident Council Minutes, dated 7/12/11, indicated the residents had concerns of the nurses not being able to keep track of aides when an aide is needed on the 300 and 500 halls. The facility response indicated the facility was awaiting repair of the walkie talkies and when they are available all staff will use them every shift for better communication.</p> <p>Review of the Resident Council Minutes, dated 8/9/11, indicated the</p>	F0244	<p><b>F 244</b></p> <p><b>Corrective Action for Affected Residents:</b> All resident council minutes from May to present have been reviewed and all concerns have been addressed. Monitoring implemented to ensure concerns are addressed and will be revised accordingly.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> All residents have the potential to be affected. All resident council minutes from May to present have been reviewed and all concerns have been addressed. Monitoring implemented to ensure concerns are addressed and will be revised accordingly.</p> <p><b>Measures to Ensure Practice does not Recur:</b> All resident council minutes from May to present have been reviewed and all concerns have been addressed. Monitoring implemented to ensure concerns are addressed and will be revised accordingly. The facility's grievance policy and procedure was reviewed and no changes are indicated at this time.</p>	11/08/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>residents had concerns of the CNA's turning off the call lights and forgetting to come back to provided the care the residents requested. The facility response was "in process of purchasing walkie for better communication amongst staff."</p> <p>Review of the Resident Council Minutes, dated 10/10/11, indicated the residents continued to have concerns related to the staff turning off call lights and forgetting to return without meeting the resident's needs. There was no facility response with the minutes.</p> <p>During a 10/20/11, 8:30 a.m., interview with the Director of Nursing, she indicated the walkie talkies had been down for a few months and the facility had just resumed using them within the last week to ten days. She indicated staff is to answer the call lights and if they can't complete the task they should use the walkie talkie to let another staff member know what the resident needs. She indicated the call light should not be turned off until the staff are ready to meet the resident's request. She indicated residents should receive a.m. and p.m. care.</p> <p>During an interview with the</p>		<p>Department Heads were in-serviced on 10/24/2011 in regards to grievance policy and procedure.</p> <p><b>This Corrective Action will be Monitored by:</b> The Administrator shall be responsible to review Resident Council Minutes and documented follow-up/response to ensure issues are promptly resolved and said resolution documented. (See Attachment N) In addition, the Administrator/Designee to conduct 5 resident interviews weekly times 4 weeks, then 5 resident interviews bi-weekly times 4 weeks, then 5 resident interviews monthly, then 5 resident interviews quarterly for a minimum of 6 months to ensure continued compliance with response to grievances voiced by the residents. Should concern be noted, corrective action shall be taken and documented. (See Attachment G) A report of progress will be forwarded to the QA Committee quarterly at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted.</p> <p><b>Date of Completion:</b> 11/8/11</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

	<p>Administrator on 10/20/11 at 3:12 p.m., she indicated the facility initiated the nurses to inquire about care and call light response from three residents each shift and document the responses on the 24 hour reports at the 8/31/11 Quality Assurance meeting. The administrator indicated the facility had initiated monitoring of call lights on 9/12/11, and the monitoring was revised on 9/30/11, to include placement of the call light. Staff education was given on 9/30/11. She indicated the problem was discussed in the 10/12/11 Quality Assurance meeting and it was determined that the monitoring needed to be continued.</p> <p>3.1-3(l)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0250 SS=D	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure Social Services reviewed and updated health care plans related to discharge planning and/or long term placement for 1 of 1 residents in a Stage 2 sample of 33 (Resident #55).</p> <p>Findings include:</p> <p>1.) Resident #55's clinical record was reviewed on 10/20/11 at 1:55 p.m.</p> <p>Diagnoses for Resident #55 included, but were not limited to, hypertension, diabetes mellitus, and depression.</p> <p>A Social Services admission note, dated 8/4/11, indicated the specific reason for admission was short term placement to receive physical and occupational therapies.</p> <p>A Social Services progress note, dated 8/10/11, indicated the resident wanted to discharge to home when she was stable.</p> <p>A Social Services initial assessment, dated 8/10/11, indicated the resident expressed the desire to return to the</p>	F0250	<p><b>F 250</b></p> <p><b>Corrective Action for Affected Residents:</b> Resident #55 did not experience any negative outcome related to lack of documented discharge planning and/or long term care placement. Resident #55's clinical record has been reviewed and up-dated as indicated.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, all residents' clinical records have been reviewed and up-dated as indicated to include documented discharge planning and/or long term placement..</p> <p><b>Measures to Ensure Practice does not Recur:</b> The facility's discharge/long term care placement policy and procedure has been reviewed and no changes are indicated at this time. Social Service staff was in-serviced on 10/24/2011 in regards to discharge planning/long term placement policy and procedure. All residents' clinical records have been reviewed and up-dated as indicated.</p>	11/08/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>community. The assessment also indicated the resident's support person was positive towards the resident's discharge. The projected discharge date was anticipated to be within 31-90 days.</p> <p>The resident's clinical record lacked any health care plans related to discharge planning and/or long term placement.</p> <p>During an interview with Social Services Staff #1 on 10/20/11 at 3:45 p.m., additional information was requested related to the lack of current health care plan reviews related to discharge planning for Resident #55.</p> <p>During an interview on 10/20/11 at 4:00 p.m., with the Social Services Staff #1, she provided a health care plan related to discharge planning which had been discontinued on 10/4/11. She indicated the resident was now going to be long- term placement, and she further indicated that the resident's family desired long-term placement. She provided no information to indicate the resident was aware of the decision.</p> <p>During an interview with the Director of Nursing, on 10/21/11 at 9:22 a.m.,</p>		<p><b>This Corrective Action will be Monitored by:</b> SSD/Designee to review all new admissions within 2 working days to ensure appropriate care plan for discharge planning/long-term placement is developed. SSD/Designee to review all new admissions weekly times 90 days to ensure appropriate discharge planning/long term care placement care plan is appropriate, then all residents to be reviewed at quarterly care plan meeting and/or with significant changes. (See Attachment H) A report of progress will be forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted.</p> <p><b>Date of Completion:</b> 11/8/11</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>she indicated Resident #55's chart lacked a health care plan related to discharge planning and/or long term placement.</p> <p>On 10/21/11 at 10:00 a.m., the Director of Nursing provided a health care plan related to long term placement initiated 10/20/11.</p> <p>2.) Review of the current, undated, facility policy, titled "CARE PLAN DEVELOPMENT AND REVIEW PROCEDURE," provided by the RN Consultant on 10/21/11, at 10:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE:</p> <p>To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs.</p> <p>POLICY...</p> <p>...4. Care plans are revised as changes in the resident's condition dictate. Changes in the resident must be immediately addressed on the care plan...</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

	...7. Care plans are reviewed and revised as changes occur daily..."  3.1-34(a)			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0253 SS=B	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure resident bathrooms and facility hallway ceilings were properly maintained and in good repair for 3 of 22 resident bathrooms observed (Room numbers 307, 403 and 501) and 1 of 4 hallway ceilings observed ( 400 hall ceiling).</p> <p>Findings include:</p> <p>During the environmental tour with the Maintenance Director and the Administrator on 10/19/11 at 1:30 p.m., the following concerns were identified,</p> <p>a. The bathroom in Room 307 had an area on the wall above the sink approximately 3 feet long and 4 inches wide that was rough and discolored. The bathroom walls were a yellow color and the rough areas were white in color. At the time of the observation the Maintenance Director indicated the light fixture had been replaced in the bathroom and the wall needed to be patched and painted.</p> <p>b. The bathroom in Room 403 had 2 areas on the wall adjacent to the toilet approximately 2 inch square that were</p>	F0253	<p><b>F 253 Corrective Action for Affected Residents:</b></p> <p>1.The bathroom walls in Room 307 have been patched and bathroom re-painted.</p> <p>2.The bathroom walls in Room 403 have been patched and bathroom re-painted.</p> <p>3.The toilet in bathroom 501 has been re-caulked. The wooden bathroom door has been repaired.</p> <p>4.The ceiling in the 400 hall has been repaired.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, all rooms have been inspected for repairs and a schedule of repairs has been developed. <b>Measures to Ensure Practice does not Recur:</b> Maintenance Director and Assistant were in-serviced on 10/24/2011 in regards to maintaining a sanitary, orderly, and comfortable interior. All rooms have been inspected for repairs and a schedule of repairs has been developed. Maintenance Director/Assistant to maintain schedule of repairs and up-date as indicated. <b>This Corrective Action will be Monitored by:</b> Maintenance Director/Assistant to complete facility inspection monthly to ensure continued compliance.</p>	11/08/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>rough and discolored. The bathroom walls were yellow in color and the rough areas were white. At the time of the observation the Maintenance Director indicated the towel bar had been replaced and the wall needed to be patched and painted.</p> <p>c. The toilet in the bathroom in Room 501 had sections of caulk missing from around the stool, the caulk that was in place was discolored and brown in color. The wooden bathroom door had an area approximately 2 inches in length that was gouged and the wood was missing.</p> <p>d. The 400 hallway ceiling had 7 areas where the ceiling texture was uneven and did not match up with the surrounding ceiling area. During an interview with the Maintenance Director, at the time of the observation, he indicated the sections of the ceiling needed to be repaired.</p> <p>3.1-19(f)(5)</p>		(See Attachment I) A report of findings/scheduled repairs will be forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, as warranted. <b>Date of Completion: 11/8/11</b>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0272 SS=D	<p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continance;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and                      Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure the nursing staff completed "Urinary and Bowel Continance Evaluations" correctly for 1 of 3 residents reviewed for correct assessment of urinary and bowel incontinence in a Stage 2</p>	F0272	<p><b>F 272</b></p> <p><b>Corrective Action for Affected Residents:</b>                      Resident #21 did not experience any negative outcomes related to the incorrect bowel and bladder assessment. The urinary bowel and bladder assessment has been up-dated and care plan up-dated to reflect current status</p>	11/08/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>sample of 33. (Resident #21)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #21 was reviewed on 10/20/11 at 1:30 p.m.</p> <p>Diagnoses for Resident #21 included, but were not limited to, encephalopathy, mental retardation, and constipation.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 5/6/11, indicated Resident #21 required assistance of the staff for toileting. The assessment indicated the resident was "continent" of both bowel and bladder.</p> <p>A "Urinary and Bowel Continence Evaluation," dated 5/5/11, indicated Resident #21 had no history of incontinence and was continent of both bowel and bladder.</p> <p>A nursing note entry, dated 7/26/11 at 1:00 a.m., indicated Resident #21 was incontinent of bowel and bladder and care had been provided.</p> <p>A nursing note entry, dated 8/5/11 at 1:00 a.m., indicated Resident #21 was incontinent of bowel and bladder</p>		<p>of resident #21.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, a review of all residents' bowel and bladder assessments and corresponding care plans has been conducted and assessments up-dated as indicated to ensure that they accurately reflect each resident's current status. Nursing staff was in-serviced on 10/31/2011 in regards to assessments and accuracy of those assessments.</p> <p><b>Measures to Ensure Practice does not Recur:</b> Nursing staff was in-serviced on 10/31/2011 in regards to assessments and accuracy of those assessments. Bowel and bladder policy and procedure were reviewed and no changes were indicated at this time.</p> <p><b>This Corrective Action will be Monitored by:</b> D.O.N/Designee will monitor Bowel and bladder assessments and care plans for all new admissions within 7 business days to ensure accuracy of resident's current status. D.O.N/Designee to review all new admissions weekly times 90 days to ensure accurate bowel and bladder assessment reflects the resident's current status, then all residents will be reviewed at</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>and care had been provided.</p> <p>A quarterly MDS, dated 8/6/11, indicated the resident continued to need the assistance of the staff for toileting and was "frequently incontinent" of bowel and bladder.</p> <p>A "Urinary and Bowel Continence Evaluation" quarterly reassessment, dated 8/5/11, indicated there had been no significant change in the resident's bowel/bladder continence since the last assessment completed on 5/5/11.</p> <p>During an interview with the Director of Nursing (DoN) on 10/20/11 at 4:00 p.m., additional information was requested regarding the discrepancies in the resident's continence status between the MDS and the Urinary and Bowel Continence Evaluations noted above.</p> <p>During an interview on 10/20/11 at 4:10 p.m., the DoN indicated the resident had been incontinent at the previous facility prior to this admission and had been incontinent since admission to this facility. She indicated the admission MDS and the Urinary and Bowel Continence Evaluations noted above had been completed in error.</p>		<p>quarterly care plan meeting and/or with significant changes. (See Attachment J) Should non-compliance with documented accurate assessment be noted, immediate corrective action and re-education shall be implemented. A report of progress will be forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted.</p> <p><b>Date of Completion: 11/8/11</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>2.) A review of the current "Bladder and Bowel Rehabilitation Program" policy, dated 3/05, provided by the RN Consultant on 10/21/11 at 10:00 a.m., included, but was not limited to, the following:</p> <p>"Purpose: To promote continence through means of bladder and/or bowel retraining or individualized habit programs based on the resident's cognitive ability....</p> <p>...1. Complete the Bladder assessment from at admission, annually, and with significant changes, to determine if they are a candidate for a formal retraining program or a habit training program. Complete the short form reviews on back of full assessment quarterly...."</p> <p>3.1-31(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review, and interview, the facility failed to ensure health care plans related to discharge planning and/or long term placement were reviewed and updated for 1 of 1 residents in a Stage 2 sample of 33 (Resident #55).</p> <p>Findings include:</p> <p>1.) Resident #55's clinical record was reviewed on 10/20/11 at 1:55 p.m.</p> <p>Diagnoses for Resident #55 included, but were not limited to, hypertension, diabetes mellitus, and depression.</p> <p>The resident's clinical record lacked</p>	F0280	<p><b>F 280 Corrective Action for Affected Residents:</b> Resident #55 did not experience any negative outcome related to lack of documented discharge planning and/or long term care placement. Resident #55's clinical record has been reviewed and up-dated as indicated. <b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, all residents' clinical records have been reviewed and up-dated as indicated to accurately address discharge planning and/or long term placement. <b>Measures to Ensure Practice does not Recur:</b> The facility's discharge/long term care placement policy and procedure has been reviewed and no</p>	11/08/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>any health care plans related to long term placement.</p> <p>During an interview with Social Services Staff #1 on 10/20/11 at 3:45 p.m., additional information was requested related to the lack of current health care plan reviews related to long term placement for Resident #55.</p> <p>During an interview on 10/20/11 at 4:00 p.m., with the Social Services Staff #1 she indicated the resident was now going to be long term placement, and she further indicated that the resident's family desired long term placement. She provided no information to indicate the resident was aware of the decision. She indicated she had not updated the health care plan to reflect long term placement.</p> <p>During an interview with the Director of Nursing, on 10/21/11 at 9:22 a.m., she indicated Resident #55's chart lacked a health care plan related to long term placement.</p> <p>On 10/21/11 at 10:00 a.m., the Director of Nursing provided a health care plan related to long term placement initiated 10/20/11.</p>		<p>changes are indicated at this time. Social Service staff was in-serviced on 10/24/2011 in regards to discharge planning/long term placement policy and procedure. All residents' clinical records have been reviewed and up-dated as indicated. <b>This Corrective Action will be Monitored by:</b> SSD/Designee to review all new admissions within 2 working days to ensure appropriate care plan for discharge planning/long-term placement is developed. SSD/Designee to review all new admissions weekly times 90 days to ensure appropriate discharge planning/long term care placement care plan is appropriate, then all residents to be reviewed at quarterly care plan meeting and/or with significant changes. (See Attachment H) A report of progress will be forwarded to the QA Committee quarterly at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted. <b>Date of Completion:</b> 11/8/11</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>2.) Review of the current, undated, facility policy, titled "CARE PLAN DEVELOPMENT AND REVIEW PROCEDURE," provided by the RN Consultant on 10/21/11, at 10:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE:</p> <p>To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs.</p> <p>POLICY...</p> <p>...4. Care plans are revised as changes in the resident's condition dictate. Changes in the resident must be immediately addressed on the care plan...</p> <p>...7. Care plans are reviewed and revised as changes occur daily..."</p> <p>3.1-35(d)(2)(B)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0309 SS=G	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure care was provided to prevent non-pressure open areas and skin irritation for 1 of 1 resident (Resident #20) observed for pericare in the Stage 2 sample of 23. In addition, the facility failed to ensure a sputum specimen was collected timely to ensure appropriate treatment for 1 of 1 resident reviewed with orders for a sputum culture (Resident #103) in a Stage 2 sample of 23.</p> <p>Findings include:</p> <p>1.) Resident #20's clinical record was reviewed on 10/20/11 at 9:57 a.m. The resident's diagnoses included, but were not limited to, depression; altered mental status; psychosis secondary to dementia; Parkinson's disease; arthritis; urinary frequency; schizoaffective disorder with delusions and agitation; anxiety; Alzheimer's disease with delusions; and dementia.</p> <p>The resident had a 9/16/11, annual</p>	F0309	<p><b>F 309</b> <b>Corrective Action for Affected Residents:</b> Resident #103 no longer resides at the facility. The groin on Resident #20 is healed, bilateral breasts are healed, and abdominal folds have improved.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, the following corrective actions have been taken:</p> <p><b>Measures to Ensure Practice does not Recur:</b> Nursing staff was in-serviced on 10/31/2011 in regards to the policy and procedures related to peri-care, A.M and P.M. care, toileting, dignity, MD notification, and following MD orders. Hospice Aide was re-educated in regards to proper shower technique. All policy and procedures listed above were reviewed with no changes indicated at this time.</p> <p><b>This Corrective Action will be Monitored by:</b> D.O.N/Designee to monitor</p>	11/08/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Minimum Data Set Assessment. The assessment indicated the resident required the extensive assistance of two or more persons for all activities of daily living except eating.</p> <p>An observation of Resident #20 was made on 10/19/11 at 11:32 a.m. Three CNA's ambulated the resident to the bathroom. The Assistant Director of Nursing was also present. The resident smelled of urine and her pants were wet in the front and back. CNA #1 indicated the resident had been incontinent of urine. CNA #2 only washed the rectal area of the resident. She did not cleanse the urine from the resident's peri/groin area, buttocks, or thighs. CNA #1 indicated the resident's abdominal folds were red. The skin, of the right and left abdominal folds, was red and shiny. No observation was made by the CNA's of the groin area at that time.</p> <p>On 10/20/11 at 1:10 p.m., the Assistant Director of Nursing indicated the resident had just had a shower provided by the hospice aide and the resident had red areas below her breasts, in her abdominal folds and groin. She indicated the resident had no open areas. An observation was made at that time of the</p>		<p>resident care on 5 residents daily on scheduled work days on varying shifts times 4 weeks, then 5 residents weekly times 4 weeks, then 5 residents monthly to ensure continued compliance. Should concerns be observed, immediate corrective action including re-education shall be taken. (See Attachment F) D.O.N./Designee to review nurse's notes and physician orders including lab and culture orders daily on scheduled work days on an ongoing basis and these items will be discussed at each morning meeting to ensure proper follow through in response to a physician order and continued compliance therewith. (See Attachment K) A report of progress will be forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted.</p> <p><b>Date of Completion: 11/8/11</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>resident's skin. The resident was sitting in the shower chair waiting to be dressed. There were red areas as indicated by the Assistant Director of Nursing. A 0.4 by 0.4 centimeter open area was observed in the resident's right groin. There was a white residue between the resident's thighs and groin area. The hospice aide indicated nothing had been applied to the resident's skin after the shower. The Assistant Director of Nursing identified the residue as powder. She indicated the resident needed to be washed better.</p> <p>The resident's record lacked any indication of the excoriated areas noted by CNA #1 on 10/19/11 at 11:32 a.m.</p> <p>The resident's "Skin Condition Flowsheets for Non-pressure Related Skin Conditions" were reviewed and indicated the following; 10/14/11, excoriation below breasts healed. 10/20/11, 0.4 by 0.4 centimeter pink superficial area in the right groin. 10/20/11, 5 by 8 centimeter pink area in the right outer abdominal fold. 10/20/11, 3 by 3 centimeter pink area in the left outer abdominal fold. 10/20/11, 5 by 10 centimeter pink area below the right breast.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>10/20/11, 7 by 10 centimeter pink area below the left breast. The 10/20/11, flowsheets were initiated after the shower observation by the Assistant Director of Nursing.</p> <p>During an interview with two of Resident #20's family members on 10/18/11 at 1:15 p.m., they indicated the resident was not receiving a.m. and p.m. care.</p> <p>During an interview with the resident's roommate [Resident #104] on 10/19/11 at 8:51 a.m., she indicated the staff did not perform a.m. and p.m. care on Resident #20. She indicated the staff frequently leave the bathroom door open and she can see they just use powder and do not wash Resident #20. She indicated the staff just get them dressed of a morning and night.</p> <p>The current 9/05, "Bedtime Care Procedure" was provided by the Nurse Consultant on 10/20/11 at 3:39 p.m. The purpose of the procedure was to prepare the resident for night. The procedure indicated the resident was to be assisted with washing their hands, face, and perineal area.</p> <p>The current 1/06, "Perineal Care" policy was provided by the Director of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>Nursing on 10/20/11 at 10:20 a.m. The purpose of the policy was to cleanse the perineum for prevention of infection, irritation, and to contribute to the resident's positive self-image. Steps to the procedure included, but were not limited to, provide privacy, wipe from front to back and from the center of perineum to thighs. The labia is to be separated and the urethral area should be cleansed first. The resident should be washed between and outside the labia in downward strokes, alternating from side to side and moving outward to the thighs.</p> <p>2.) The clinical record for Resident #103 was reviewed on 10/20/11 at 9:50 a.m.</p> <p>Diagnoses for Resident #103 included, but were not limited to, chronic obstructive pulmonary disease, cachexia, and anorexia.</p> <p>A health care plan problem, dated 9/20/11, indicated Resident #103 had an upper respiratory infection with bilateral lower lobe infiltrates. The problem indicated the staff were to administer Rocephin (an antibiotic) 1 gram intramuscularly (IM) daily times 5 days and obtain a sputum specimen</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>for culture.</p> <p>The nurses notes indicated the resident developed increased respiratory concerns with rales and crackles noted on 9/20/11. The resident's physician was contacted and an order was received for a chest x-ray and a one time dose of Rocephin 1 gram IM. The resident also had orders for suctioning as needed and nebulizer breathing treatments.</p> <p>A chest x-ray report, dated 9/20/11, indicated the resident had "slight bilateral lower lobe infiltrates".</p> <p>The physician was contacted in regards to the chest x-ray report and a second physician's order, dated 9/20/11, indicated the resident was to receive Rocephin 1 gram IM daily times 5 days and the staff were to obtain a sputum specimen for culture and sensitivity.</p> <p>A sputum culture and sensitivity final report, dated 9/29/11, indicated a specimen had been sent for testing on 9/27/11. The report indicated the culture was positive for a heavy growth of the organism "enterobacter aerogenes." The report listed "ceftriaxone" (Rocephin) on the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>antibiotic sensitively list. The report indicated the effectiveness of the Rocephin medication against the organism was an "I" for intermediate in effect. The report listed 7 other antibiotics to which the organism was more sensitive.</p> <p>The clinical record lacked any information related to attempts to obtain the sputum specimen prior to the entry on 9/27/11 at 1:00 p.m., which indicated the specimen was obtained by the respiratory department. This indicated a time period of 7 days from the date the order to for sputum testing was received and the specimen was obtained for testing.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 10/20/11 at 1:00 p.m., additional information was requested regarding the delay in obtaining the sputum culture for testing.</p> <p>During an interview on 10/21/11 at 10:00 a.m., the DoN indicated she had talked with the nursing staff and respiratory therapy departments. They indicated they had tried to obtain a specimen earlier after the order was received, but had been unsuccessful and the she did not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>know why they had not tried again prior to 9/27/11. The nursing notes lacked any information related to any attempts to obtain the specimen prior to 9/27/11.</p> <p>Review of the current facility policy titled "Specimen Collection Procedure-Sputum", dated 9/05, provided by the RN Consultant on 10/21/11 at 10:00 a.m., included, but was not limited to, the following:</p> <p>"Purpose- To obtain a specimen of sputum for diagnostic analysis.</p> <p>...Procedure:</p> <ol style="list-style-type: none"> <li>1. Explain procedure to resident and bring equipment to bedside...</li> <li>3. Instruct resident to deeply cough from the chest and expectorate into container.</li> <li>4. Use suction machine and sterile catheter if resident is unable to produce specimen....</li> <li>7. Complete laboratory request form. Send with specimen to laboratory. Avoid delay....</li> <li>8. Chart procedure on nursing record...." </li></ol>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------------	--	---------------------	--	----------------------------

	3.1-37(a)			
--	-----------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0315 SS=G	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 resident who met the criteria incontinence care received proper perineal care to prevent infection and/or skin conditions and was toileted on a schedule to prevent incontinence in a Stage 2 sample of 23. [Resident #20]</p> <p>Findings include:</p> <p>Resident #20's clinical record was reviewed on 10/20/11 at 9:57 a.m. The resident's diagnoses included, but were not limited to, depression; altered mental status; psychosis secondary to dementia; Parkinson's disease; arthritis; urinary frequency; schizoaffective disorder with delusions and agitation; anxiety; Alzheimer's disease with delusions; and dementia.</p> <p>The resident had a 9/16/11, annual Minimum Data Set Assessment. The</p>	F0315	<p><b>F 315</b></p> <p><b>Corrective Action for Affected Residents:</b> The groin of Resident #20 is healed, bilateral breasts are healed, and abdominal folds have improved. Resident #20's bowel and bladder assessment has been reviewed and up-dated as indicated to reflect her current status. Plan of care is being followed as indicated.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, the following corrective actions have been taken:</p> <p><b>Measures to Ensure Practice does not Recur:</b> Nursing staff was in-serviced on 10/31/2011 in regards to policy and procedures related to peri-care, A.M and P.M. care, toileting, bowel and bladder, and dignity. All policy and procedures listed above were reviewed with</p>	11/08/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>assessment indicated the resident required the extensive assistance of two or more persons for all activities of daily living except eating. The assessment indicated the resident was not on a toileting program and was frequently incontinent.</p> <p>The resident had a 9/20/11 care plan problem of having incontinent episodes related to a decreased ability to get to and from the toilet/commode/bedpan. Some interventions to the problem included, but were not limited to, toileting the resident before and after meals and as needed throughout the night. The care plan indicated the resident's program should be reviewed quarterly to assess if changes need to be made to the current toileting schedule.</p> <p>The resident's most recent 24-Hour Bladder Voiding Diary was initiated 1/19/10 at 3:00 p.m., and completed on 1/21/10 at 11:00 p.m. The diary indicated the resident was to be checked every hour and if continent or does not need to void to leave blank. The diary indicated the resident was incontinent on the following dates and times: 1/19/10 at 3:00 p.m., and 6:00 p.m. 1/20/10 at 2:00 a.m. 1/21/10 at 12:00 a.m., 3:00 a.m., 6:00</p>		<p>no changes indicated at this time.</p> <p><b>This Corrective Action will be Monitored by:</b> D.O.N/Designee to monitor resident care on 5 residents daily on scheduled work days on varying shifts times 4 weeks, then 5 residents weekly times 4 weeks, then 5 residents monthly to ensure continued compliance. (See Attachment F) Should non-compliance be observed, immediate corrective action including re-education shall be taken. D.O.N/Designee will monitor Bowel and bladder assessments and care plans for all new admissions within 7 business days to ensure accuracy of resident's current status. D.O.N/Designee to review all new admissions weekly times 90 days to ensure accurate bowel and bladder assessment reflects the resident's current status, then all residents will be reviewed at quarterly care plan meeting and/or with significant changes. (See Attachment J) A report of progress will be forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted.</p> <p><b>Date of Completion: 11/8/11</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>a.m., 9:00 a.m., 2:00 p.m., 7:00 p.m., 9:00 p.m. and 11:00 p.m.</p> <p>The resident had a 6/30/11 quarterly reassessment of her urinary and bowel continence and her retraining potential was determined as she would be able to participate in a toileting program. A 9/16/11 evaluation had not been completed related to the retraining potential and if the resident was able to participate in a toileting program.</p> <p>The resident had a 9/18/11, urine culture indicating the resident had greater than 100,000 CFU/ml [colony forming units/milliliter] of Escherichia Coli and 50 - 60,000 CFU/ml of Proteus Mirabilis. The resident received Bactrim DS antibiotic two times a day for seven days for a urinary tract infection.</p> <p>The resident was observed in her room sitting in her wheelchair at 8:45 a.m., on 10/19/11. The resident was taken to activities and returned to her room. No toileting was observed until 11:32 a.m. Three CNA's ambulated the resident to the bathroom. The Assistant Director of Nursing was also present. The resident smelled of urine and her pants were wet in the front and back. CNA #1 indicated the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>resident had been incontinent of urine. CNA #2 only washed the rectal area of the resident. She did not cleanse the urine from the resident's peri/groin area, buttocks, or thighs. CNA #1 indicated the resident had been toileted after breakfast.</p> <p>On 10/20/11 at 1:10 p.m., the Assistant Director of Nursing indicated the resident had just had a shower provided by the hospice aide. She indicated the resident had no open areas. An observation was made at that time of the resident's skin. The resident was sitting in the shower chair waiting to be dressed. There were red areas as the indicated by the Assistant Director of Nursing. A 0.4 by 0.4 centimeter open area was observed in the resident's right groin. There was a white residue between the resident's thighs and groin area. The hospice aide indicated nothing had been applied to the resident's skin after the shower. The Assistant Director of Nursing identified the residue as powder. She indicated the resident's groin needed to be washed better.</p> <p>During an interview with two of Resident #20's family members on 10/18/11 at 1:15 p.m., they indicated the resident was not receiving a.m.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>and p.m. care. They indicated they didn't think the staff toileted the resident enough because the resident was going through too many outfits during the day.</p> <p>During an interview with the resident's roommate [Resident #104] on 10/19/11 at 8:51 a.m., the roommate indicated the staff did not perform a.m. and p.m. care on Resident #20. Resident #104 indicated the staff frequently leave the bathroom door open and she can see they just use powder and do not wash Resident #20. She indicated the staff just get them dressed of a morning and night. She indicated she was present when the staff returned Resident #20 to her room after breakfast that morning and the staff did not offer to toilet Resident #20 upon returning her to her room.</p> <p>During an interview with the Director of Nursing on 10/20/11 at 10:24 a.m., she indicated an Inservice had been given to the CNA's related to infection prevention and perineal care on 5/16/11.</p> <p>The current 1/06, "Perineal Care" policy was provided by the Director of Nursing on 10/20/11 at 10:20 a.m.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>The purpose of the policy was to cleanse the perineum for prevention of infection, irritation, and to contribute to the resident's positive self-image. Steps to the procedure included, but were not limited to, provide privacy, wipe from front to back and from the center of perineum to thighs. The labia is to be separated and the urethral area should be cleansed first. The resident should be washed between and outside the labia in downward strokes, alternating from side to side and moving outward to the thighs.</p> <p>The current undated "Bladder &amp; Bowel rehabilitation Program" was provided by the Nurse Consultant on 10/20/11 at 3:39 p.m. The purpose was to promote continence through means of bladder and/or bowel retraining or individualized habit programs based on the resident's cognitive ability and to keep the resident clean and dry and to enhance continence by providing routine or scheduled intervals of toileting assistance. The bladder rehabilitation procedure indicated the bladder assessment form should be completed annually and with a significant change to determine if the resident is a candidate for a formal retraining program. The voiding</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>pattern does not need to be completed annually if there is no significant change. The bladder habit training program is determined from the results of the voiding pattern diary.</p> <p>3.1-41(a)(2)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure nursing staff washed their hands according to facility policy for 1</p>	F0441	<p><b>F 441</b></p> <p><b>Corrective Action for Affected Residents:</b> Resident did not experience any</p>	11/08/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>of 1 nurses observed who administered medications to a resident via a gastrostomy tube when handwashing was indicated. (LPN #3)</p> <p>Findings include:</p> <p>During a medication pass observation with LPN #3 on 10/17/11 at 3:35 p.m., the following was observed,</p> <p>LPN #3 went to the medication cart to prepare a medication for administration. The nurse did not wash her hands prior to preparing the medication. LPN# 3 tossed paper supplies towards the trash can on the medication cart. The paper landed on the floor next to the medication cart. LPN #3 picked the paper up off the floor and placed the paper in the trash can. The nurse did not wash her hands and or use hand gel. LPN #3 left the medication cart with the medication and entered the resident's room. LPN #3 then left the resident's room and went to the nurses station to obtain supplies. LPN #3 re-entered the resident's room. She then lifted the resident's clothing and placed a stethoscope on the resident's abdomen to check for the gastrostomy tube placement. LPN #3 then went into the bathroom and washed her hands for approximately</p>		<p>negative outcome related to this alleged negative practice. LPN #3 is no longer employed at the facility.</p> <p><b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> All residents with a gastrostomy tube have the potential to be affected. No other residents were affected by this alleged negative practice. LPN #3 is no longer employed at the facility.</p> <p><b>Measures to Ensure Practice does not Recur:</b> All nursing staff was in-serviced on 10/31/2011 in regards to hand washing and medication administration. All nursing staff was checked off on skills for hand washing. All nurses were checked off for skills on medication administration.</p> <p><b>This Corrective Action will be Monitored by:</b> D.O.N/Designee to monitor medication administration (See Attachment L) and hand washing (See Attachment M) on 5 residents daily on scheduled work days on varying shifts times 4 weeks, then 5 residents weekly times 4 weeks, then 5 residents monthly to ensure continued compliance. Should non-compliance be observed, immediate corrective action, including re-education, shall be taken. A report of progress will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>5 seconds. She turned the water faucet on and off with her bare hands. LPN #3 then donned gloves and administered the medication through the gastrostomy tube. LPN #3 then removed her gloves and went to the bathroom and washed her hands for approximately 5 seconds. She used her bare hands to turn the water faucet on and off .</p> <p>During an interview with the Director of Nursing on 10/20/11 at 10:24 a.m. indicated the nursing staff knew about proper handwashing techniques. She further indicated she had given a mandatory facility inservice related to handwashing and infection control on 5/16/11.</p> <p>Review of the current undated facility policy, titled "Enteral Feeding Tube - Medication Administration" provided by the Director of Nursing on 10/20/11 at 10:20 a.m. indicated the following,</p> <p>" Purpose: To assure proper administration of medications via an enteral feeding tube.</p> <p>Procedure:</p> <p>1. Prepare meds according to order and take to bedside.</p>		<p>forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted.</p> <p><b>Date of Completion: 11/8/11</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>2. Wash hands thoroughly and explain procedure to resident..."</p> <p>Review of the current undated facility policy, titled "Handwashing Procedure", provided by the Director of Nursing on 10/20/11 at 10:20 a.m. indicated the following,</p> <p>"Policy:</p> <p>To provide protection for resident and staff when performing direct care procedure. to ensure that hands remain clean so as to assist in maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Prepare paper toweling.</li> <li>2. Turn on the faucet with paper towel; adjust water to a comfortable temperature.</li> <li>3. Apply soap to hands from the dispenser.</li> <li>4. Angle arms down holding hands lower than elbows. Wet hands and</li> </ol>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>wrists. Rub vigorously for at least 15 seconds...</p> <p>7. Pat hands dry with paper towel.</p> <p>8. Turn off faucets with paper towel and discard towel immediately in waste receptacle."</p> <p>3.1-18(l)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0520 SS=E	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to ensure the Quality Assurance committee evaluated and implemented a procedure to ensure call lights were being answered timely following repeated resident, family, and resident council concerns being voiced which resulted in emotional distress, pain, and discomfort for 1 of 3 residents reviewed for assistance with toileting in a Stage 2 sample of 33. (Resident #104)</p> <p>Findings include:</p>	F0520	<p><b>F 520</b> An Informal Dispute Resolution is being requested. <b>Corrective Action for Affected Residents:</b> Resident #104 denies any further abdominal pain or crying occurrences related to call light response times. <b>Other Residents Having the Potential to be Affected and Corrective Action Taken:</b> As all residents have the potential to be affected, the following corrective action has been taken: <b>Measures to Ensure Practice does not Recur:</b> Department Heads were in-serviced on 10/24/2011 in regards to QA policy and</p>	11/08/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>1.) Review of the Resident Council Minutes, dated 7/12/11, indicated the residents had concerns of the nurses not being able to keep track of aides when an aide is needed on the 300 and 500 halls. The facility response indicated the facility was awaiting repair of the walkie talkies and when they are available all staff will use them every shift for better communication.</p> <p>Review of the Resident Council Minutes, dated 8/9/11, indicated the residents had concerns of the CNA's turning off the call lights and forgetting to come back to provided the care the residents requested. The facility response was "in process of purchasing walkie for better communication amongst staff."</p> <p>Review of the Resident Council Minutes dated 10/10/11, indicated the residents continued to have concerns related to the staff turning off call lights and forgetting to return without meeting the resident's needs. There was no facility response with the minutes.</p> <p>During a 10/20/11, 8:30 a.m., interview with the Director of Nursing, she indicated the walkie talkies had</p>		<p>procedure, including identification of care concerns and drafting and implementing a plan to resolve said concern(s).. QA policy and procedure was reviewed and no changes were indicated at this time. <b>This Corrective Action will be Monitored by:</b> Administrator/Designee will review all resident council minutes monthly to ensure any concerns are addressed by the QA committee via drafted action plan and monitoring, in an effort the concern be corrected in a timely manner. (See Attachment N) A report of progress will be forwarded to the QA Committee quarterly for a minimum of 6 months at which the need for continued monitoring will be discussed and adjusted accordingly, if warranted. <b>Date of Completion:</b> 11/8/11</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011	
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>been down for a few months and the facility had just resumed using them within the last week to ten days. She indicated staff is to answer the call lights and if they can't complete the task they should use the walkie talkie to let another staff member know what the resident needs. She indicated the call light should not be turned off until the staff are ready to meet the resident's request. She indicated residents should receive a.m. and p.m. care.</p> <p>During an interview with the administrator on 10/20/11 at 3:12 p.m., she indicated the facility initiated the nurses to inquire about care and call light response from three residents each shift and document the responses on the 24 hour reports at the 8/31/11 Quality Assurance meeting. The administrator indicated the facility had initiated monitoring of call lights on 9/12/11, and the monitoring was revised on 9/30/11, to include placement of the call light. Staff education was given on 9/30/11. She indicated the problem was discussed in the 10/12/11 Quality Assurance meeting and it was determined that the monitoring needed to be continued.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>2.) During an interview with Resident #20's family members on 10/18/11 at 1:15 p.m., they indicated they had observed Resident #104 crying and complaining of abdominal pain on 10/16/11. They indicated they were visiting with Resident #104's roommate [Resident #20] at the time. They indicated Resident #104 had turned on her call light. The family members indicated Resident #104 was watching the door and told them she observed two CNA's walking together past her door without acknowledging the call light two separate times while waiting to go to the bathroom.</p> <p>Resident #104 was interviewed on 10/19/11 at 8:51 a.m. Resident #104 indicated on Sunday [10/16/11] around 4:00 p.m., she had to go to the bathroom and had turned on the call light and no one would come. She indicated her roommate's family were present and had tried to find staff to help her, but they could not find any. She indicated she had seen two staff members walk pass the door two different times and not come in. She stated "I was crying because I had to go to the bathroom and it made my stomach hurt. I have had two bladder surgeries and was told I was going to have problems holding</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>my urine the rest of my life."</p> <p>The current 9/05, "Call Light Procedure" was provided by the Nurse Consultant on 10/20/11 at 3:39 p.m. The policy indicated the purpose was to allow the resident to request assistance when needed. The procedure indicated the call light should be within reach of the resident at all times and answered promptly.</p> <p>3.) Review of current undated facility policy, titled "Quality Improvement Program", provided by the Administrator on 10/21/11 at 10:50 a.m., included, but was not limited to, the following:</p> <p>"I. Goal</p> <p>To provide consistent comprehensive and ongoing resident care.</p> <p>II objectives</p> <p>A. to assure that quality care is provided to the residents prior to, at the time of and after the delivery of care.</p> <p>...C. To identify areas in need of improvement in resident care.</p> <p>D. To attain and maintain customer</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

	<p>satisfaction.</p> <p>E. To implement action for resolution of known problem areas at the time of care delivery.</p> <p>F. To provide audit tools whereby immediate implementation of corrective actions is take at the point of care deliver....</p> <p>VII. Program Implementation - Documentation</p> <p>A. It is the responsibility of each department to complete their own quality improvement reviews timely and accurately...."</p> <p>3.1-52(b)(2)</p>			
--	---	--	--	--