STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	5911 STATE ROAD 46 ELLETTSVILLE, IN 47429

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 8, 9, 10, 11 and 12, 2024 Facility number: 000558 Provider number: 155523 AIM number: 100267550 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 3 Medicaid: 41 Other: 12 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 16, 2024.	F 0000	**The facility respectfully requests paper compliance for this citation** ***This plan of correction is the centers credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.***	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jacqueline Routt 08/04/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on interview and record review, the facility failed to ensure the resident's representative was informed of the baseline care plan for 1 of 1 residents reviewed for mood and behavior. (Resident 56)	F 0655	**F655 Comprehensive Person-Centered Care Planning** 1 Immediate action taken. A comprehensive care plan	08/07/2024

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	Finding include: On 7/11/24 at 10:15 a.m., Resident 56' clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety, and insomnia. His admission date was 6/6/24. Resident 56's Interim 48 hour baseline care plan was started on 6/6/24. The clinical record lacked documentation of the resident's representative being informed of the baseline care plan. During an interview on 7/12/24 at 10:24 a.m., the Social Service Designee (SSD) indicated when a new admission was admitted, the facility would have a 72 hour care plan with the family to go over the baseline care plan. During an interview on 7/12/24 at 11:44 a.m., the SSD indicated the clinical record lacked documentation of the 72 hour care plan meeting with family. On 7/12/24 at 11:59 a.m., the Regional Operational Support provided the the facility policy, "Resident/Family Participation - Assessment/Person Centered Care Plans," revision date of 4/2017, and indicated it was the policy currently being used. A review of the policy indicated, "...5. After baseline care plan is developed a care conference will be held with the resident/representative within 72 hours of admission..."		with the resident's representative for resident number 56 was completed on 7/29/2024. 2 How the facility plans to establish compliance. An audit was completed on 7/25 for all admissions in the last 30 days to identify any missed care plans within the 48 hours' time frame with no findings. An Inservice was completed with the Social Service Director/ Designee on 7/29 by the Executive Director on the "Resident/Family participation for a person-centered care plan" with emphasis on the completion of the documentation for a 48 hour care plan meeting. 3 Measures put into place/ system changes. A weekly facility audit has been initiated to ensure that all 48 hours care plans are completed with the patient and or responsible party. The Social Service Director or Designee will randomly audit 3 admissions 3 x a weeks for 4 weeks, then 2 x a week x 4 weeks, followed by weekly x 4 months. 4 How the corrective action will be monitored. The results of these audits will be reviewed in the Quality Assurance Meeting monthly	

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			for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical			

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	services. Based on interview and record review, the facility failed to ensure staff completed a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, and a post-discharge plan of care developed with the participation of the resident for 1 of 1 resident reviewed for discharge. (Resident 58) Findings include: On 7/11/24 at 11:34 a.m., Resident 58's clinical record was reviewed. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, bipolar II disorder, major depressive disorder, anxiety, abnormalities of gait and awareness, cognitive communication deficit, sleep disorder, dysphagia (difficulty swallowing foods or liquids), and need for assistance with personal care. A 4/17/24 discharge Minimum Data Set (MDS) assessment indicated the resident required supervision for self care and ambulation. A review of the resident's progress notes indicated the following: - On 4/10/24 the resident notified the social worker she was going to discharge to Missouri on 4/17/24 at 5:00 p.m. She would go home without home health care or services because she was going out of state. - On 4/17/24 at 3:40 p.m., the resident came to the social worker and asked for her money from the safe. The Assistant Director of Nursing and social worker gave her the money.	F 0661	**F 661 Discharge Summary** 1 Immediate action taken. Resident number 58 no longer resides in the facility. 2 How the facility plans to establish compliance. An audit of all discharged residents in the last 30 days was completed to identify incomplete discharge summaries and corrected as needed. An in-service was provided on 7/30/24 by the Executive Director with the MDS Coordinator, Director of Nursing, and Social Service Director on the "Discharge Planning Process" 3 Measures put into place/ system changes. A weekly facility audit has been initiated to ensure that all discharge summaries are completed in their entirety and presented to the resident upon discharge. The Director of Nursing or Designee will randomly audit 3 discharge summaries 3 x a weeks for 4 weeks, then 2 x a week x 4 weeks, followed by weekly x 4 months 4 How the corrective action will be monitored. The results of these audits	08/07/2024

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	- On 4/17/24 at 3:55 p.m., a "Discharge note" on the resident indicated she was a DNR (do not resuscitate). She was given a Brief Interview for Mental Status (BIMS; an assessment used to evaluate a patient's cognitive state) and had no cognitive impairment. She was given the Patient Health Questionnaire (PHQ; a self-report inventory that helps diagnose and screen for mental health disorders) and scored a 0. She has had no behavior or psychosis. She planed to return to Missouri with family. Her medication was called into a local retail pharmacy. Her discharge plans were to leave the state. - On 4/17/24 at 7:15 p.m., the resident left the facility with family and all belongings. No other documentation was located in the resident's clinical record in regard to her discharge from the facility. During an interview on 7/11/24 at 2:45 p.m., the Social Services Director (SSD) indicated she was responsible for discharge services and nursing was responsible for medication reconciliation. She indicated staff should complete the "Discharge Summary" page prior to a resident's discharge. During an interview on 7/11/24 at 2:56 p.m., the SSD indicated she was unable to locate the completed discharge summary, including a recapitulation of stay in the resident's clinical record. She believed it was because the facility was in between two systems when the resident discharged from the facility, however, it should have been completed. On 7/12/24 at 12:01 p.m., the Director of Nursing provided the facility policy, "Discharge Planning Process," dated 1/10/18, and indicated it was the		will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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	policy currently being used. A review of the policy indicated, "... 10. For anticipated discharges, Social Services or designees will invite the resident and/or resident's representative(s) ... to a Discharge Care conference(s) prior to the resident's discharge from the facility..." The policy did not indicated documentation of a discharge summary or recapitulation of resident stay. 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to provide respiratory care for 1 of 1 residents reviewed. Oxygen tubing was not changed. (Resident 18) Findings include: On 7/9/24 at 12:35 p.m., Resident 18 was observed lying in bed with oxygen (O2) being administered via nasal cannula (NC) at 2 liters (L). The nasal cannula was dated 6/8/24. On 7/10/24 10:40 a.m., Resident 18 was observed	F 0695	**F 695 Respiratory Care** 1 Immediate action taken. The oxygen tubing was changed and dated for resident number 18. 2 How the facility plans to establish compliance. An audit of all resident's requiring oxygen was completed on 7/11/24 with no further	08/07/2024

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	lying in bed with O2 being administered via NC at 2 L. The nasal cannula was dated 6/8/24. On 7/10/24 1:18 p.m., Resident 18 was observed sitting in wheel chair with portable oxygen being administered at 2 L via NC, the NC tubing was dated 4/28 (no year indicated). On 7/10/24 2:43 p.m., Resident 18 was observed lying in bed without oxygen on. She indicated she knew she was supposed to wear it at all times but she took it off at times. The NC was lying on the bed next to resident, which was dated for 6/8/24. Resident 18 picked up the tubing and placed in her nose at that time. The NC observed on portable oxygen was dated 4/28. On 7/11/24 9:36 a.m., Resident 18 was observed lying in bed without oxygen on. The NC was lying on bed next to resident, dated for 6/8/24. The NC observed on portable oxygen was dated 4/28. On 7/11/24 12:05 p.m., Resident 18 was observed sitting outside with portable oxygen being administered at 2 L via NC which was dated 4/28. At that time Director of Nursing (DON) indicated tubing was dated for 4/28. On 7/10/24 at 1:54 p.m., Resident 18's clinical record was reviewed. The diagnoses included, but were not limited to, altered respiratory status, history of sleep apnea, myotonic (an inability to relax muscles at will) muscular dystrophy (progressive muscle degeneration, with weakness and shrinkage of the muscle tissue), pneumonia, personal history of pulmonary embolism (a blood clot that develops in a blood vessel elsewhere in the body and travels to an artery in the lung). The Quarterly Minimum Data Set (MDS)		findings. An in-service was provided by the Director of Nursing on 7/30 with all licensed personnel on the policy for "Oxygen Administration" with emphasis on scheduled tubing change process. 3 Measures put into place/ system changes. A weekly facility audit has been initiated to ensure that all oxygen tubing is changed weekly. The Director of Nursing or Designee will randomly audit 5 of all ordered oxygen tubing 3 x a weeks for 4 weeks, then 2 x a week x 4 weeks, followed by weekly x 4 months 4 How the corrective action will be monitored. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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	assessment, dated 5/13/24, indicated the resident utilized oxygen therapy. The Care Plan, dated 2/2/24, indicated Resident 18 had altered respiratory status. The interventions included, but were not limited to, change, date, and label tubing weekly. The Physician's Orders included, but were not limited to: - Oxygen at 2 liter/minute via nasal cannula to maintain oxygen saturations above 90% every shift (start date 9/10/23). - Date, label, and change oxygen cannula and tubing every seven days, once a day on Saturday (start date 8/17/23). During an interview on 7/11/24 12:05 p.m., with the Director of Nursing (DON), the DON indicated Resident 18 had order for oxygen therapy. The DON indicated nasal cannula tubing was dated 6/8/24, and portable oxygen tubing was dated 4/28. The DON indicated tubing dates were outdated and should have been changed weekly on Saturdays. On 7/12/24 at 10:00 a.m., the DON provided the facility policy, "Oxygen Administration," dated 3/30/20, and indicated it was a policy currently being used. A review of the policy indicated, "...5. Assure humidifier (as applicable) and oxygen tubing is changed every 7 days, unless otherwise required by manufacturer or state regulation..." 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility			

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	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to label a vial (glass container for holding liquid medication) with the opened date for 1 of 2 medication rooms observed. Findings include: On 7/12/24 at 9:20 a.m., the refrigerator in the medication room was observed to have vial of Tubersol (a solution to aid in diagnosis of tuberculosis infection) in a box. The vial and the box lacked an opened date. The Director of Nursing (DON) could not find an opened date, and all opened vials should have an opened date	F 0761	**F 761 Labeling of Medications** 1 Immediate action taken. The TB solution was immediately discarded upon identification. 2 How the facility plans to establish compliance. All stored Tubersol/Aplisol were checked for proper dates with no further findings. An in-service was provided on 7/30 with all licenses personnel by the director of nursing on the	08/07/2024

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	on them. On 7/12/24 at 9:45 a.m., the DON provided the facility's policy, "Determining Expiration Dates," undated and indicated it was the policy being used by the facility. A review of the policy indicated "...Tubersol/Aplisol...30 days once opened (Refrigerated)..." 3.1-25(j)		policy for “Determining Expiration Dates” with emphasis on documenting opening and expiration dates. 3 Measures put into place/ system changes. A weekly facility audit has been initiated to ensure that all Tubersol/Aplisol is properly dated and discarded of. The Director of Nursing or Designee will randomly audit the med rooms 3x weekly for 4 weeks, then 2 x a week x 4 weeks, followed by weekly x 4 months 4 How the corrective action will be monitored. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	