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	05/09/2025

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. This visit included the Investigation of Complaint IN00457596. Complaint IN00457596 - No deficiencies related to the allegations are cited. Survey dates: May 5, 6, 7, 8, and 9, 2025 Facility number: 000558 Provider number: 155523 AIM number: 100267550 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 2 Medicaid: 48 Other: 8 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 15, 2025.	F 0000	This facility requests paper compliance for this survey. This Plan of Correction is the center's 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 alleged facts or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. ="" p="">	
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions Based on record review and interview, the facility failed to ensure residents and/or their representative were provided informed consent prior to initiating an antipsychotic medication for 1 of 6 residents reviewed for unnecessary medications. (Resident 13)	F 0552	Resident #13 was provided informed consent related to antipsychotics. ="" p=""> ="" p=""> ="" p="">	06/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keona Parkison	Divisional Director of Operations	06/04/2025

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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	Findings include: On 5/6/25 at 2:09 p.m., Resident 13's clinical record was reviewed. The diagnoses included, but were not limited to, myotonic muscular dystrophy (a genetic disorder characterized by progressive muscle weakness and difficulty relaxing muscles after use), psychosis (significant loss of contact with reality, often characterized by hallucinations and delusions), and senile degeneration of the brain (a decline in cognitive function). A review of physician's orders indicated the following: On 4/29/25, an order for Olanzapine (an antipsychotic medication) 2.5 mg (milligrams) once daily was prescribed for a diagnosis of psychosis. A review of Resident 13's progress notes indicated the following: On 4/29/25, the resident informed staff that she saw an accident take place that had multiple casualties. The resident was seen by her primary care doctor and psychologist, both providers recommended to start resident on Olanzapine 2.5 mg daily, due to continued hallucinations. The record indicated the family was aware. The clinical record lacked documentation that indicated informed consent was provided to the resident and the resident representative regarding treatment options, risks, and benefits of psychotropic medication. During an interview with the DON (Director of Nursing), on 5/9/25 at 11:52 a.m., she indicated there was not an informed consent prior to the		Any resident residing in the facility who receives an antipsychotic medication has the potential to be affected by the alleged deficient practice. All identified individuals were provided informed consent. Re-education was provided to all licensed staff and SSD with emphasis on obtaining informed consent prior to the initiation of psychotropic medications on or before 6/11/2025. The SSD/designee will audit all newly ordered psychotropic medications to ensure informed consent is completed prior to initiating medication x 6 months. Education will be provided immediately for failure to do so. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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 of correction as indicated.	

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	start of a psychotropic medication. On 5/9/25 at 1:57 p.m., the DON indicated they did not have a policy for initiating psychotropic medication, nor did they have a policy on obtaining informed consent. 3.1-3(n)(2)			
F 0553 SS=D Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care Based on interview and record review, the facility failed to ensure resident's care planning conferences were completed for 1 of 1 residents reviewed for care planning. (Resident 41) Finding includes: During an interview on 5/6/25 at 9:48 a.m., Resident 41 indicated the staff did not involve him or his family in care conferences, and he could not remember the staff ever involving him with the development of his care plan. On 5/6/25 at 11:10 a.m., the resident's clinical record was reviewed. The diagnoses included, but were not limited to hemiplegia (complete paralysis on one side) and hemiparesis (partial weakness on one side of the body) following a cerebral infarction (a condition where brain tissue dies due to a lack of blood flow) affecting left non-dominant side, need for assistance with personal care, dysphagia following cerebrovascular disease, and cerebral infarction without residual deficits. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/25, indicated the resident	F 0553	A care conference was held with Resident #41. ="" p=""> ="" p=""> Any resident residing in the facility has the potential to be affected by the alleged deficient practice. An audit was completed to ensure all residents have had a care conference in the last 90 days. Any identified were offered the opportunity to participate in a care conference and completed as requested. Re-education was provided to the IDT with emphasis on completing care conferences with the resident and/or representative. The SSD/designee will audit 3 residents 5 days a week for 4 weeks, then 3 residents 3 days a week for 4 weeks, then 3 residents weekly for 4 weeks, then 3 residents monthly x 4 months to ensure a care conference is	06/15/2025

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	had moderately impaired cognition. A review of the resident's clinical record indicated his last care conference was on 6/2/24 and his Annual MDS assessment was dated 8/9/24. During an interview on 5/7/25 at 9:50 a.m., the Director of Nursing (DON) indicated the care conference documentation should appear under "care planning" or "observations" tab. She verified there were no care conferences located under in the resident's record and she would verify it on her end. During an interview on 5/9/25 at 2:00 p.m., the DON indicated the resident's last care conference was in 2024 and they should be done quarterly. On 5/9/25 at 2:20 p.m., the DON provided the facility policy, "Care Planning-Resident Participation," undated, and indicated it was the policy currently being used. A review of the policy indicated, "This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care) ... 10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan ... at routine intervals ... 11. If the participation of the resident and/or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record." 3.1-35(d)(2)(B)		offered and completed per facility policy. 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 of correction as indicated.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences			

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	Based on observation, interview, and record review, the facility failed to ensure reasonable accommodation of needs for 1 of 5 residents interviewed during the resident council meeting. Call lights were not within reach. (Resident 55) Findings include: During a resident council meeting on 5/7/25 at 10:01 a.m., Resident 55 indicated she did not have access to her call light. Resident 55 indicated the staff had recently deep-cleaned their room and they did not have use of their call lights for 24 hours. Resident 55 insisted she still did not have access to her call light because it was under a stack of plastic totes in their room. On 5/7/25 at 10:45 a.m., Resident 55's call light was observed on the floor, under a plastic storage container. She would not have had prompt access to call for help. On 5/7/25 at 11:00 a.m., Resident 55's clinical record was reviewed. The diagnoses included, but were not limited to, unsteadiness on feet, difficulty in walking, need for assistance with personal care, and glaucoma. The Quarterly Minimum Data Set (MDS) assessment, dated 1/16/25, indicated the resident had moderately impaired cognition. On 5/8/25 at 9:29 a.m., Resident 55 was observed in her recliner and putting on her shoes. Her call light remained on the floor, under the plastic container. She indicated she did not have access to her call light because it was still under the plastic container. She then got up and went to activities.	F 0558	Resident 55's call light was immediately placed within reach. All residents have the potential to be affected by the alleged deficient practice. An audit of all resident call lights was conducted, and all were found to be within reach of residents. All employees were re-educated on the residents' right to reasonable accommodation and preferences. Employees were also re-educated in identifying a call light prior to exiting the resident room to ensure the resident have access. The Executive Director or will audit 5 resident rooms to ensure call lights are within reach of residents. This audit will take place 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks and monthly for 3 months to ensure deficient practice does not recur. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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 of correction as indicated.	06/15/2025

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	On 5/9/25 at 2:20 p.m., the Director of Nursing provided the facility policy, "Call Lights: Accessibility and Timely Response," dated 1/22/25, and indicated it was the policy currently being used. A review of the policy indicated, "... 5. Staff will ensure the call light is within reach of resident and secured as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room ..." 3.1-3(v)(1)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on observation, interview, and record review, the facility failed to promptly respond to grievances from the resident council meetings for 5 of 5 residents interviewed. (Resident 11, Resident 31, Resident 55, Resident 45, Resident 41) Findings include: During a resident council meeting on 5/7/25 at 10:01 a.m., Resident 11, Resident 31, Resident 55, Resident 45, and Resident 41, indicated if a meal included a wet item, such as corn, their bread was often soggy and unappetizing. The resident's indicated they had told staff this was a problem multiple times and it was an ongoing problem. A review of the resident council meeting minutes indicated the following: - On 12/26/24, the residents indicated they would like separate dishware for liquid type foods, such as, cottage cheese, fruit, baked beans, etc.	F 0565	Resident 11, Resident 31, Resident 55, Resident 45 and Resident 41 were all met individually to discuss food related grievance and informed that wet food items will be served in separate bowls. All residents were affected. All employees were educated in grievance procedures on or before 6/11/2025. Residents were also provided with grievance procedures during the resident council meeting to ensure prompt attention and resolution. The Executive Director or will audit all resident and family grievances for 6 months to ensure deficient practice does not recur. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 6 months or until 100% compliance is achieved	06/15/2025

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	- On 2/27/25, the residents discussed the need of bowls for liquid foods. - On 3/27/25, the residents indicated when liquid foods were on the plate with regular food, the sandwiches, or breads would get soggy. On 5/7/25 at 12:10 p.m., a test tray was obtained from the 300 hall cart. The meal included a hamburger on a bun, fried onion rings, and whole kernel corn on a flat plate. The corn was beneath the bun and a few onion rings were on top of the corn. The bottom of the hamburger bun and the onion rings placed on top of the corn were soggy. During an interview on 5/8/25 at 11:29 a.m., the Dietary Manager indicated he was not aware of the residents' concerns related to soggy food. 3.1-3(l)		x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0574 SS=C Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information Based on observation, interview, and record review, the facility failed to ensure residents were informed of the state and local advocacy organization and contact information for filing complaints. This had to potential to affect 58 out of 58 residents residing in the facility. Findings include: During a resident council meeting on 5/7/25 at 10:36 a.m., residents indicated they did not know where the State Survey Agency (SSA) or the State Long-Term Care Ombudsman information was posted. They further indicated they did not know how to file a complaint with the State Survey	F 0574	No residents were found to be affected. All residents have the potential to be affected. Local advocacy information was moved to wheelchair level. Information was also reviewed during the resident council meeting and provided in writing to all residents. The Executive Director or will interview 3 residents monthly for 6 months to ensure they know where to find contact information for local advocacy organizations	06/15/2025

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	Agency. During an observation on 5/7/25 at 10:49 a.m., the local advocacy information was observed posted up by the front entrance approximately 4 and one half feet from the floor. The posting was located amongst other papers and was not easily identifiable nor within eyesight of a wheelchair bound resident. On 5/7/25 at 3:20 p.m., the resident council meeting minutes were reviewed. The resident council meeting minutes did not indicate the SSA or ombudsman posting information was discussed during meetings. During an interview on 5/9/25 at 2:05 p.m., the Clinical Nurse Consultant indicated a staff member should go over the local advocacy posting information during resident council meetings and the residents were provided a copy at admission. She further indicated the facility did not have a specific policy in regard to the posting of local advocacy agencies. 3.1-4(j)(3)(A) 3.1-4(j)(3)(C)		and how to contact them. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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 of correction as indicated.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to ensure the resident representative was notified of a change in condition and treatments for 1 of 1 resident's reviewed for death. (Resident 57) Findings include: On 5/6/25 at 2:31 p.m., Resident 57's closed clinical	F 0580	=”” p=””> Resident #57's representative was notified of the change of condition and treatment orders but was not documented. Any resident with a change in condition has the potential to be affected by the alleged deficient	06/15/2025

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	record was reviewed. The diagnoses included, but were not limited to, dementia, muscle weakness, need for assistance with personal care, and stage 3 chronic kidney disease. A review of the resident's progress notes indicated the following: - On 3/1/25 at 10:22 p.m., the resident was ordered 2 liters (2 bags) of sodium chloride solutions for dehydration. His son and wife were notified. The note was recorded as a late entry on 3/2/24 at 10:24 p.m. - On 3/2/25 at 3:35 a.m., the sodium chloride (0.9% NaCl) solutions were completed via hypodermoclysis (the subcutaneous infusion of fluids, a hydration technique suitable for mildly to moderately dehydrated adult patients). - On 3/2/25 at 7:56 a.m., the resident had fatigue, a change in mental status, and dark urine. The note did not indicate the family had been notified. - On 3/2/25 at 9:32 p.m., the resident had congestion, fever, and a productive cough. The note did not indicate the family had been notified. - On 3/2/25 at 11:17 p.m., the resident was lethargic, his oxygen saturation was 94 percent on room air (normal level is typically between 95% and 100%), and his respirations were 26 (normal respiratory rate for a resting adult is typically between 12 and 20 breaths per minute). The Nurse Practitioner ordered 1 liter of dextrose and sodium chloride (D5W/NaCl, a combination of a sugar and a salt used as a source of water, electrolytes, and calories), followed by 1 liter of sodium chloride. The note did not indicate the family had been notified.		practice. An audit was completed for any changes of conditions from 5/22/2025 to present to ensure any responsible party of any resident with a change of condition has been notified and documented as such. Re-education was provided to all licensed staff on or before 6/11/2025 with emphasis on notification of responsible parties with changes of condition and documentation. The DON/designee will audit 3 residents 5 days a week for 4 weeks, then 3 residents 3 days a week for 4 weeks, then 3 residents weekly for 4 weeks then 3 residents monthly x 4 months to ensure responsible parties were notified of any change of condition and documented as such. Education will be provided immediately for failure to do so. 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 of correction as indicated.	

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	- On 3/2/25 at 11:30 p.m., the D5W/NaCl was subcutaneously running at 75 milliliters per hour. The note did not indicate the family had been notified. - On 3/3/25 at 6:20 a.m., the resident was found with no pulse or respirations. A second nurse confirmed his death. On 5/7/25 at 2:23 p.m., LPN 2 indicated she was not working when the resident expired. She indicated he was diagnosed with COVID-19 a few days prior to death and he had recently recovered from a UTI (urinary tract infection). She was surprised to learn he passed away. On 5/7/25 at 3:20 p.m., the DON provided the facility policy, "Notification of Changes," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... The facility must ... notify the resident's family member ... when there is a change requiring such notification. Circumstance requiring notification include: ... 2. Significant change in the resident's physical, mental ... condition such as deterioration in health ... 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment ..." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0641 SS=D Bldg. 00	483.20(g)(h)(i)(j) Accuracy of Assessments Based on record review and interview, the facility failed to ensure an accurate MDS (Minimum Data Set) assessment for 2 of 2 residents reviewed for	F 0641	The MDS was modified and resubmitted to show corrected data for both Resident #31 and	06/15/2025

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	resident assessment. (Resident 31, Resident 11) Finding includes: 1. On 5/8/25 at 2:52 p.m., Resident 31's clinical record was reviewed. The diagnoses included, but were not limited to, bipolar disorder (a mental health condition causes extreme mood swings), dementia (a group of diseases that affect your thinking, memory, reasoning, personality, mood and behavior), and mood disorder (a mental health condition characterized by significant and persistent changes in mood). A review of the notice of PASARR (Preadmission Screening and Resident Review) Level II Outcome, dated 5/22/23, indicated, "Final Determination By:.. Determination Date: 5/22/23, Level II Outcome: Long Term Approval without Specialized Services." The Annual MDS assessment, dated 6/27/24, did not indicate resident was a PASARR level II. During an interview with the Clinical Reimbursement Director on 5/9/25 at 12:15 p.m., she indicated section A1500 on MDS assessment, dated 6/27/24, was marked no in error and indicated it should have been marked yes for PASARR Level II. She indicated they did not have a MDS assessment coding policy, they followed the Resident Assessment Instrument (RAI) manual for coding the MDS assessment. On 5/9/25 at 1:30 p.m., a review of the RAI, Version 3.0 User's Manual, 10/2023, for section A1500 of MDS indicated, "Code 1, yes: if PASARR Level II screening determined that the resident has a serious mental illness and/or ID (Intellectual disability)/DD (Developmental		Resident #11. ="" p="">
 ="" p="">
  Any resident residing in the facility who requires an MDS assessment has the potential to be affected by the alleged deficient practice. The last OBRA MDS submission was audited for all residents for accuracy with data corrected and resubmitted if necessary. Re-education was provided to MDSC/SSD/AD with emphasis on accuracy of MDS assessment on or before 6/11/2025. The MDSC/designee will audit 3 OBRA MDS assessments weekly x 6 months for accuracy. Corrections will be made immediately. 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 of correction as indicated.	

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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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	disability) or related condition..." 2. On 5/8/25 at 3:04 p.m., Resident 11's clinical record was reviewed. The diagnoses included, but were not limited to, heart disease without heart failure, chronic respiratory failure with hypoxia (a condition where the lungs struggle to adequately transfer oxygen into the blood, leading to chronically low oxygen levels), and dementia. An order, dated 5/8/24, indicated hospice services were provided by the hospice provider. The Quarterly MDS assessment, dated 4/3/25, was not marked for hospice care services. During an interview with the Clinical Reimbursement Director on 5/9/25 at 12:15 p.m., she indicated that Resident 11 was receiving hospice services during the quarterly assessment period and Section O0110 on the MDS should have been marked yes. She indicated they did not have a MDS assessment coding policy, they followed the RAI manual for coding the MDS assessment. On 5/9/25 at 1:30 p.m., a review of the RAI, Version 3.0 User's Manual, 10/2023, for section O0110 of MDS indicated, "...check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days...Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided..." 3.1-31(d)			
F 0679 SS=E	483.24(c)(1) Activities Meet Interest/Needs Each Resident			

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Bldg. 00	Based on observation, interview, and record review, the facility failed to implement an ongoing resident centered activities program for 13 of 13 residents who resided on the secure dementia unit. Findings include: On the following dates and times, residents of the secured dementia unit were observed walking in the hallway, and sitting in the dining area and common area with no structured activities taking place: - On 5/5/25 from 11:00 a.m. to 12:30 p.m. and from 2:00 p.m. to 3:05 p.m. - On 5/6/25 from 9:40 a.m. to 12:15 p.m. and from 1:40 p.m. to 2:55 p.m. - On 5/7/25 from 9:45 a.m. to 11:55 a.m. and from 1:20 p.m. to 3:00 p.m. - On 5/8/25 from 9:30 a.m. to 11:05 a.m. No activities schedule was observed posted or located on the closed dementia unit. During confidential interviews during the course of the survey, they indicated there had been no activities calendar or schedule posted on the unit for several months, and no scheduled activities had taken place for several months, including the survey period. On occasion, an activities assistant would come to the unit to do unscheduled activities with the residents. Activities were inconsistently provided for residents on the unit. The nursing staff would do random and unscheduled activities with the residents when not attending to resident nursing care needs. During an interview on 5/8/25 at 11:15 a.m., the	F 0679	Residents who reside in the secure dementia unit were found to be affected. Activity calendars designed to meet the needs of residents in the dementia u were implemented and posted on the 400 unit. All residents have the potential to be affected. Nursing staff were re-educated on resident centered activities and meeting the needs and interests of residents with dementia on or before 6/11/2025. Certified Dementia Practitioner will design and implement resident activity calendar specific to secure dementia unit. Activity calendars will be posted throughout the unit. The Executive Director or will review resident activity calendar monthly for 6 months to ensure resident centered activities are scheduled. The Executive Director or will audit 5 random activities to ensure they are carried out at scheduled times weekly for 4 weeks and then monthly for 5 months to ensure the deficient practice does not recur. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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 of correction as indicated.	06/15/2025

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	Executive Director indicated there was a need for regularly scheduled activities on the secure dementia unit. On 5/09/25 at 1:21 p.m., the Executive Director provided the facility Admission Statement, undated, and indicated this was the Admission Statement currently used by the facility. A review of the statement indicated, "...These services are provided under the daily basic rate for residents regardless of the payor source...an activities program, including, but not limited to, a planned schedule for recreational , motivational, social, and other activities..." 3.1-33(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary interventions to prevent the development of a pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. A resident developed a Stage 3 pressure ulcer. (Resident 38) Findings include: During an observation on 5/6/25 at 2:56 p.m., Resident 38 was observed to be resting in her bed on her back and her heels were on the bed. Her heels were not observed to be floated on pillows. During an observation on 5/7/25 at 9:43 a.m., Resident 38 was observed to be resting in the bed on her back and her heels were on the bed. Her heels were not observed to be floated on pillows. During an observation on 5/7/25 at 1:57 p.m.,	F 0686	Resident #38 plan of care was reviewed and updated to ensure appropriate interventions are in place and followed to prevent the development of a pressure ulcer. ="" p=""> ="" p=""> All residents have the potential to be affected to be affected by the alleged deficient practice. An audit was completed on any resident with a Braden score of 13 or below to ensure appropriate interventions are in place and followed. Re-education was provided to all licensed staff on or before 6/11/2025 with emphasis on ulcer	06/15/2025

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	Resident 38 was observed to be resting in the bed on her back and her heels were on the bed. Her heels were not observed to be floated on pillows. During an observation on 5/8/25 at 9:30 a.m., Resident 38 was observed to be resting in the bed on her back and her heels were on the bed. Her heels were not observed to be floated on pillows. During an observation on 5/9/25 at 9:04 a.m., Resident 38 was observed to resting in the bed on her back and her heels were on the bed. Her heels were not observed to be floated on pillows. On 5/7/25 at 11:11 a.m., Resident 38's clinical record was reviewed. The diagnoses included, but were not limited to, stage 3 pressure ulcer of the sacral (lower back) region, dementia, diabetes mellitus, and muscle weakness. The Clinical Quarterly assessment, dated 3/20/25 at 3:37 p.m., indicated Resident 38 was at a moderate risk for pressure ulcers and was dependent on staff for rolling from left to right side when lying on back in the bed. The quarterly MDS (Minimum Data Set) assessment, dated 3/25/25, indicated Resident 38 had severe cognitive impairment, required maximum assist with rolling from left to right side when lying on back in the bed, was always incontinent of bowel and bladder, was at risk for skin breakdown, and did not have any pressure ulcers. The care plan, dated 11/23/22, indicated Resident 38 was at risk for pressure related skin breakdown due to mobility deficit and incontinence. The interventions were to encourage Resident 38 to turn and reposition every 2 hours and as needed;		prevention and interventions. The DON/designee will audit 3 residents 5 days a week for 4 weeks, the 3 residents 3 days a week for 4 weeks, then 3 residents weekly x 4 weeks then 3 residents monthly x 3 months to ensure ulcer prevention interventions are in place and followed. Education will be provided immediately for failure to do so. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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 of correction as indicated.	

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	provide thorough skin care with any incontinent episode; and to keep bony prominences from prolonged contact with surfaces. The care plan, dated 3/28/25, indicated Resident 38 was at risk for complications from a stage 3 pressure ulcer to coccyx. The interventions lacked documentation of turn and reposition or to float heels. The Wound Management Detail Report, dated 3/31/25 at 1:04 a.m., indicated the following: - On 3/31/25 at 1:22 p.m., Resident 38 was evaluated for a new stage 3 pressure ulcer to her coccyx. She was incontinent of bowel and bladder. She had poor mobility and was bed and chairfast. The pressure ulcer was 1.2 cm (centimeters) x (by) 0.5 cm x 0.1 cm. The treatment recommendations were to cleanse the coccyx with normal saline, apply collagen (wound dressing) to the base of the wound, and cover with a gauze. The preventive measures were to turn and reposition per protocol; pressure reduction to the heels and all bony prominences; and to float the heels while in the bed with the use of pillows. All prevention measures were discussed with the staff at the time of the visit. - On 4/8/25 at 8:56 p.m., Resident 38's stage 3 pressure ulcer was improving without complications. The size was 0.8 cm x 0.3 cm x 0.1 cm. The treatment recommendations were to cleanse the pressure ulcer with normal saline, apply collagen to the base of the wound, and cover with a gauze. The preventive measures were to turn and reposition per protocol; pressure reduction to the heels and all bony prominences; and to float the heels while in the bed with the use of pillows. All prevention measures were discussed with the staff at the time of the visit.			

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	- On 4/15/25 at 9:06 p.m., Resident 38's stage 3 pressure ulcer was improving without complications. The size was 0.7 cm x 0.3 cm x 0.1 cm. The treatment recommendations were to cleanse the pressure ulcer with normal saline, apply collagen to the base of the wound, and cover with a gauze. The preventive measures were to turn and reposition per protocol; pressure reduction to the heels and all bony prominences; and to float the heels while in the bed with the use of pillows. All prevention measures were discussed with the staff at the time of the visit. - On 4/23/25 at 4:12 p.m., Resident 38's stage 3 pressure ulcer was improving without complications. The size was 0.4 cm x 0.3 cm x 0.1 cm. The treatment recommendations were to cleanse the pressure ulcer with normal saline, apply collagen to the base of wound, and leave the area open to the air. The preventive measures were to turn and reposition per protocol; pressure reduction to the heels and all bony prominences; and to float the heels while in the bed with the use of pillows. All prevention measures were discussed with the staff at the time of the visit. Resident 38's progress notes indicated the following: - On 4/29/25 at 5:08 p.m., Resident 38's stage 3 pressure ulcer was improving without complications. The size was 1 cm x 0.5 cm x 0.1 cm. The treatment recommendations were to cleanse the pressure ulcer with normal saline, apply collagen to the base of the wound, and cover with a border gauze. The preventive measures were to turn and reposition per protocol; pressure reduction to the heels and all bony prominences; and to float the heels while in the bed with the use			

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	of pillows. All prevention measures were discussed with the staff at the time of the visit. - On 5/6/25 at 9:10 p.m., Resident 38's stage 3 pressure ulcer was improving without complications. The size was 0.8 cm x 0.5 cm x 0.1 cm. The treatment recommendations were to cleanse the pressure ulcer with normal saline, apply calcium alginate (wound care dressing) to the base of the wound, and cover with a border gauze. The preventive measures were to turn and reposition per protocol; pressure reduction to the heels and all bony prominences; and to float the heels while in the bed with the use of pillows. All prevention measures were discussed with the staff at the time of the visit. The clinical record lacked documentation of Resident 38 refusing to float heels or to turn and reposition. During an interview on 5/7/25 at 2:13 p.m., the Assistant Director of Nursing (ADN) indicated Resident 38 had a Stage 3 pressure ulcer to her coccyx. The root cause of the pressure ulcer was from sliding down in her wheelchair. Her interventions were to lay down after meals, turn and reposition, occupational therapy to assist with wheelchair positioning, and a wheelchair cushion to help prevent pressure ulcers. During an interview on 5/8/25 at 10:40 a.m., CAN 2 indicated Resident 38's pressure ulcer interventions were to provide incontinent care and to lay down after meals. Resident 38 did not refuse care. Resident 38 did not turn and reposition after meals or float heels when in bed. During an interview on 5/9/25 at 10:14 a.m., Qualified Medication Aide (QMA) 2 indicated			

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	Resident 38 was dependent on staff for activities of daily living (ADL). Resident 38 did not refuse care. Resident 38 was on a turn and reposition schedule. During an interview on 5/9/25 at 11:25 a.m., the Director of Nursing (DON) indicated the clinical record lacked documentation of Resident 38 refusing to turn and reposition or floating heels. On 5/9/25 at 12:14 p.m., the DON provided the facility policy, "Pressure Injury Prevention and Management," dated 1/22/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...Basic or routine care interventions could include, but are not limited to: I. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)...iii. Provide appropriate, pressure-redistributing, support surfaces;..." 3.1-40(a)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion received services to prevent further decline for 1 of 2 residents reviewed for mobility.(Resident 41) Findings include: During an interview on 5/6/25 at 9:55 a.m., Resident 41 indicated his left hand did not open and he would like to try a splint to see if that improved his left hands function and mobility. His left hand was observed to not fully open and did not have a splint in place.	F 0688	Splint for Resident 41 was immediately ordered for left hand. Residents with assisted devices have the potential to be affected. An audit of residents with assisted devices was completed and no additional residents were found to be affected. Nursing staff were re-educated on Prevention of Decline in Range of Motion policy. Therapy Director and therapists were also re-educated ones for ordering	06/15/2025

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	On 5/6/25 at 2:19 p.m., Resident 41 was observed in his room without a splint on his left hand. On 5/7/25 at 1:57 p.m., Resident 41 was observed in his bed without a splint on his left hand. He indicated staff did not do any range of motion exercises with him. On 5/6/25 at 11:10 a.m., Resident 41's clinical record was reviewed. The diagnoses included, but were not limited to hemiplegia (complete paralysis on one side) and hemiparesis (partial weakness on one side of the body) following a cerebral infarction (a condition where brain tissue dies due to a lack of blood flow) affecting left non-dominant side, need for assistance with personal care, dysphagia following cerebrovascular disease, and cerebral infarction without residual deficits. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/25, indicated the resident had moderately impaired cognition and functional limitation in range of motion with impairment on one side in his upper and lower extremities. A "Occupational Therapy OT Discharge Summary," dated 4/4/25, indicated an extensor resting hand splint was ordered and once it was delivered, OT would assess for correct fit and establish and provide education regarding a wearing schedule. A care plan titled, "ADLs Functional Status/Rehabilitation Potential", dated 5/23/24, indicated the resident was to put on a left hand brace in the morning and remove it in the evening. During an interview on 5/8/25 at 1:53 p.m.,		assistive devices for residents. The Director of Nursing or will audit 3 residents with assisted devices daily for one week, weekly for 4 weeks and then monthly for 5 months to ensure devices are in place. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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 of correction as indicated.	

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	Certified Occupational Therapy Assistant (COTA) 1 indicated she wrote the progress note in regard to the splint. She had not verified the Business Office Manager (BOM) had placed the order. During an interview on 5/8/25 at 1:54 p.m., the BOM indicated she did not know if she had placed the order for the splint and she would look the splint's order status. During an interview on 5/8/25 at 3:17 p.m., Executive Director (ED) indicated the splint's order must have not gone through. During an interview on 5/9/25 at 11:45 a.m., the Director of Nursing (DON) indicated the facility did not have restorative aides and to talk to the clinical MDS consultant in regard to range of motion exercises and the implementation of a restorative program for residents. During an interview with the Clinical Reimbursement Director she indicated the facility did not have a restorative aide and was actively looking to hire one. She confirmed the resident was not on a restorative program which would typically happen after a resident was discharged and recommended by therapy. On 5/9/25 at 2:20 p.m., the DON provided the facility policy, "Prevention of Decline in Rang of Motion," dated 1/25/25, and indicated it was the policy currently being used. A review of the policy indicated, "... 4. Preventative Care ... b. Staff will ... iii. Encouraging resident to remain active and assisting with any exercises ... iv. Assisting resident in ... use of any assistive devices. v. Assisting resident with range of motion exercises, performing passive range of motion for resident unable to actively participate. c Residents will			

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	receive services from restorative aides or therapist as needed..." 3.1-42(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff on the secured dementia unit for 13 of 13 residents who resided on the secure dementia unit (Resident 13, Resident 15, Resident 19, Resident 23, Resident 34, Resident 53, Resident 32, Resident 14, Resident 52, Resident 8, Resident 54, Resident 208, and Resident 48). Findings include: On 5/6/25 at 2:10 p.m., LPN 1 was observed attending to Resident 34 who was ambulating in an unsteady manner in the hallway. LPN 1 observed Resident 52 ambulating in an unsteady manner farther down the hallway and instructed Resident 34 to hold to the hallway railing in order to attend to Resident 52. During this time, QMA 1 was assisting a resident in a resident bathroom. CNA 1 was in the shower room with another resident. LPN 1 guided Resident 52 to a chair in the common area and returned to assist Resident 34. On 5/7/25 at 1:30 p.m. LPN 1 was observed assisting Resident 34 to a chair in the common area. CNA 1 was assisting a resident in a resident room. Resident 34 was resistant to sitting and was becoming agitated. At that time, Resident 32 was attempting to enter the room of another resident. LPN 1 instructed Resident 34 to hold onto the wall railing and redirected Resident 32 to the common	F 0725	The nursing schedule was immediately evaluated to ensure the proper number of trained nursing staff are assigned to the secured memory care unit to ensure resident safety. All residents were found to be affected. Resident care plans were reviewed to determine the physical needs of each resident residing on the secure unit. The acuity and resident diagnoses will be reviewed to determine sufficient nursing staff assigned to each shift per day. The Director of Nursing or designee will audit the nursing schedule specific to the secured dementia unit daily for 30 days, weekly for 4 weeks and then monthly for 4 months to ensure sufficient number of trained staff are assigned to the secured unit. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make	06/15/2025

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	area prior to assisting Resident 34 to a chair. No other staff were observed on the unit at that time. On 5/8/25 at 10:30 a.m., LPN 2 was observed at the far end of the unit hallway assisting Resident 52 as he ambulated in an unsteady manner. In the common area, Resident 34 was observed to begin to sit on the lap of Resident 48, who was agitated at that situation. LPN 2 assisted Resident 52 in steadying himself with the wall railing and sprinted the length of the hallway to intervene in Resident 34's attempt to sit on the lap of Resident 48. During that time, QMA 1 was in a resident room attending to a resident's toileting needs and CNA 3 was off the unit procuring supplies for the unit. Confidential interviews were conducted the course of the survey and indicated the following: - From 7:00 a.m. to 3:00 p.m., there was 1 nurse and 2 CNA's on the unit. At 3:00 p.m., one of the CNA's was pulled from the unit, either to clock out or to work in another area of the facility, which left 2 staff working on the unit from 3:00 p.m. to 7:00 p.m. At 7:00 p.m., the second shift nurse and CNA relieved the first shift staff, which left 2 staff working on the unit from 7:00 p.m. to 7:00 a.m. - Most of the residents required extensive assistance of 1 or 2 staff for transferring and toileting and were at risk of falling. - The time period between 3:00 p.m. and 11:00 p.m. was when some residents experience sundowner's syndrome (a neurological condition during which some with dementia experience increased confusion and restlessness beginning in the late afternoon and early evening), and may become agitated and more difficult to direct and redirect. If		recommendations to revise the plan of correction as indicated.	

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	one resident displayed challenging behaviors or required 2 staff to manage, this left the other residents unattended and at risk of falling. If one staff needed a bathroom break, or was attending to another resident in a resident's room, this left only 1 staff to attend to the rest of the residents. The residents were all at risk of falling, and with only 2 staff on the unit the residents were at a higher risk of falling and not receiving care that would fully meet their physical, emotional, and psychosocial needs. On 5/7/25 at 2:05 p.m., a review of the secure dementia unit staffing schedule indicated the secure dementia unit was assigned 3 nursing staff each day from 7:00 a.m. to 3:00 p.m., and 2 nursing staff each day from 3:00 p.m. to 7:00 a.m. On 5/7/25 at 2:10 p.m., a clinical record review of the residents of the secure dementia unit indicated the following: - There were 4 residents who required extensive assistance of 1 staff member for transfers from surface to surface. - There were 4 residents who required extensive assistance of 2 staff members for transfers between different surfaces. - There were 2 residents who required total assistance for transfers between different surfaces. - There were 6 residents who required extensive assistance of 1 staff member for toileting. - There were 6 residents who required extensive assistance of 2 staff members for toileting.			

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	- Between 5/1/24 and 5/7/25 there were a total of 53 fall events amongst the 13 residents on the secure dementia unit. Of those 53 falls, 39 falls occurred between the hours of 3:00 p.m. and 7:00 a.m. On 5/8/25 at 11:20 a.m., the Director of Nursing indicated indicated there were 3 staff scheduled from 7:00 a.m. to 3:00 p.m., and 2 staff scheduled to work on the dementia unit from 3 p.m. to 7 a.m. On 5/5/25 at 11:00 a.m., the ED provided the Facility Assessment Tool, copyright date of June 2024, and indicated this was the Facility Assessment Tool currently used by the facility. A review of the Facility Assessment Tool indicated, "...the facility takes into consideration all resident care needs including assist levels for ADL's [activities of daily living] and special clinical needs...the facility periodically analysis patient outcomes and negative events when determining future staffing needs...the staffing needs for each care unit are determined with consideration of the patient functional care needs..." 3.1-17(a)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure staff served food that had a palatable texture and appearance for 1 of 1 test trays observed. (Resident 11, Resident 31, Resident 55, Resident 45, Resident 41, Resident 17) Findings include: During a resident council meeting on 5/7/25 at	F 0804	The menu was immediately reviewed to identify areas with wet food items. All residents were found to be affected. The Dietary Director and Dietary employees were re-educated on food preparation methods that conserve nutritive value, flavor, and	06/15/2025

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	10:01 a.m., Resident 11, Resident 31, Resident 55, Resident 45, and Resident 41, indicated if a meal included a wet item, such as corn, their bread was often soggy and unappetizing. They indicated they had told staff this was a problem multiple times and it was an ongoing problem. On 5/7/25 at 12:10 p.m., a test tray was obtained from the 300 hall cart. The meal included a hamburger on a bun, fried onion rings, and whole kernel corn on a flat plate. The corn was beneath the bun and a few onion rings were on top of the corn. The bottom of the hamburger bun and the onion rings placed on top of the corn were soggy. During an interview on 5/7/25 at 12:15 p.m., the Administrator did not deny the hamburger bun was soggy. During an interview on 5/7/25 at 12:20 p.m., Resident 17 indicated the onion ring and hamburger buns were soggy from the corn liquid. During an interview on 5/8/25 at 11:29 a.m., the Dietary Manager indicated he was not aware of the residents' concerns related to soggy food. 1.3-21(a)(2)		appearance. Wet food items will be served in separate bowls/plate to ensure other food items do not become soggy. The Executive Director or will audit 2 random meals 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks and monthly for 4 months to ensure food is served with a palatable texture and appearance. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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 of correction as indicated.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to implement infection control practices for 1 of 11 residents observed for care. Gloves were not changed, hands were not washed, and Enhanced Barrier Precautions were not implemented. (Resident 38) Findings include:	F 0880	No negative outcomes were noted for Resident #38. ="" p=""> ="" p=""> Any resident who requires wound treatment (s) or Enhanced Barrier Precautions (EBP) has the potential to be affected by the	06/15/2025

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	During an observation of a pressure ulcer dressing change on 5/7/25 at 10:46 a.m., the Assistant Director of Nursing (ADON) went into Resident 38's room with treatment supplies to change Resident 38's pressure ulcer dressing. The ADON placed the treatment supplies on Resident 38's bed. CNA 4 performed incontinent care on Resident 38. CNA 4 removed her soiled gloves. She was observed to put on a new pair of gloves. CNA 4 was not observed to wash her hands or apply hand sanitizer prior to putting on the new gloves. The ADON removed the soiled dressing from Resident 38's coccyx. The ADON did not change her gloves after removing the old dressing and placing the new dressing on. The ADON picked up the treatment supplies and placed them back in the treatment cart. The ADON and CNA 4 were not observed to be wearing a gown during the dressing change. On 5/7/25 at 11:11 a.m., Resident 38's clinical record was reviewed. The diagnoses included, but were not limited to, stage 3 pressure ulcer of the sacral (lower back) region, dementia, diabetes mellitus, and muscle weakness. The physician orders, dated 4/8/25 through 5/8/25, lacked an order for enhanced barrier precautions (an infection control strategy that used gloves and gowns during high-contact resident care to reduce the spread of resistant organisms). The ADL (activities of daily living) Functional care plan, dated 5/13/24, indicated Resident 38 had no isolation. The care plan, dated 3/28/25, indicated Resident 38 was at risk for complications from a stage 3 pressure ulcer to coccyx. The interventions lacked		alleged deficient practice. An audit was completed to ensure EBP are in place for all residents who require the precautions. Re-education was provided to all licensed staff on or before 6/11/2025 with emphasis on clean dressing change policy and EBP. All licensed staff completed skills check off with clean dressing change with return demonstration with DON/designee. The DON/designee will audit 3 residents 5 days a week for 4 weeks, then 3 residents 3 days a week for 4 weeks, then 3 residents weekly x 4 weeks, then 3 residents monthly for 3 months to ensure EBP are in place as ordered and followed. The DON/designee will audit one licensed employee to complete a dressing change weekly x 6 months to ensure appropriate procedure. Education will be provided immediately if needed. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x 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	

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	documentation of enhanced barrier precautions. During an interview on 5/7/25 at 2:13 p.m., the ADON indicated Resident 38 had a stage 3 ulcer to her coccyx. Resident 38 should of been on enhanced barrier precautions during her pressure ulcer dressing change. When a "dirty dressing is removed", they need to wash hands and change gloves. On 5/8/25 at 1:51 p.m., the Executive Director (ED) provided the facility policy, "Clean Dressing Change," dated 4/1/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...5. Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application:...10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves..." On 5/8/25 at 1:51 p.m., the Executive Director (ED) provided the facility policy, "Enhanced Barrier Precautions," dated 1/22/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "..."Enhanced barrier precautions"...employs targeted gown and gloves use during high contact resident care activities...b. An order for enhanced barrier precautions will be obtained for residents with any of the following: 1. Wounds (e.g. chronic wounds such as pressure ulcers...)...4. High-contact resident care activities include:...h. Wound care: any skin opening requiring a dressing..." 3.1-18(b)(1)		plan of correction as indicated.	