STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 00 B. WING	12/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 28, 29, 30, December 1 and 2, 2022. Facility number: 000148 Provider number: 155526 AIM number: 100275500 Census Bed Type: SNF/NF: 61 Total: 61 Census Payor Type: Medicare: 4 Medicaid: 43 Other: 14 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 8, 2022.	F 0000	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. The Plan of Correction is prepared and submitted because of requirements under state and federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Hodgson	Health Facility Administrator	12/20/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 00 B. WING	12/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to protect a resident's right to be free from abuse, for 1 of 2 residents reviewed for abuse (Resident 23). Findings include: 1. Resident 46's closed clinical record was reviewed on 11/30/22 at 11:50 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety, schizoaffective disorder and major depressive disorder. His medication orders had included risperidone (anti-psychotic) 0.25 mg (milli-gram), twice a day. A 10/18/22, quarterly, MDS assessment indicated he had severe cognitive impairment. He required limited assistance to walk in room and in corridor as well as with locomotion on and off the unit. He received an anti-psychotic medication six days during the assessment period. A 10/22/22, discharge return anticipated, MDS assessment indicated he had discharged to a psychiatric hospital. A care plan, initiated 4/18/22 and revised 7/21/22, indicated he exhibited verbal behavioral symptoms directed towards others, threatening others and screaming at others. The interventions had included attempt to use diversion, distraction and reorientation to calm him.	F 0600	1. Resident 23 had no adverse reactions to altercation. Resident 46 no longer resides at the facility. 2. Other residents on the secured unit have the potential to be affected. Any occurrence will be analyzed, and root cause determined, as possible, to assure residents are free from resident to resident altercations. The facility has put into place interventions to prevent negative outcomes, such as immediate supervision of residents with signs of behavioral interactions, increase in activities and providing a quiet environment. 3. The facility's policy for "Abuse Prohibition, Reporting and Interventions" was reviewed and no changes are indicated at this time. Staff were re-educated on the abuse policy with special attention to assuring any immediate intervention of residents with behavioral interactions, in order to prevent further occurrences' 4. The administrator and/or designee will be responsible to monitor each occurrence daily on scheduled workdays, to assure immediate intervention of residents with behavioral disturbance. Monitoring will be completed daily, ongoing on scheduled workdays.	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 00 B. WING	12/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan, initiated 4/18/22 and revised 7/21/22, indicated he exhibited physical behavioral symptoms such as hitting and throwing objects at staff. The interventions had included try to identify the immediate cause for the behavior. A Mood and Behavior Communication Memo, dated 9/23/22 from 6:00 a.m. through 7:00 a.m., indicated he had wandered the hall and entered other resident's rooms, waking them while they were still in bed. A Mood and Behavior Communication Memo, dated 10/17/22 from 10:00 a.m. through 6:00 p.m., indicated he had been going into other resident's rooms and had hit staff when they tried to redirect him. The resident's plan of care did not indicate the development of new interventions for the resident entering others' rooms. A Mood and Behavior Communication Memo, dated 10/22/22 from 7:30 a.m. through 12:00 p.m., indicated he had walked from his room to the dining room, stopped in front of a female resident, smiled and giggled while looking at her, he started to walk towards her and had indicated he was going to kiss her when staff intervened. At noon, he had come back to the hall and talked with another resident and indicated he was going to get her and "make her a crip." A nurse progress note, dated 10/22/22 at 4:10 p.m., indicated he had a resident to resident altercation. The note lacked detail of the altercation. A social service progress note, dated 10/22/22, indicated he had went into another resident's room and had put both hands around the other		Should concerns be noted, immediate corrective action will occur. The findings of the monitoring/reviews will be reported to the QA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance. 5. 12-20-2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 00 B. WING	12/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's neck. The resident was sent to the emergency room and then transferred to an inpatient psychiatric hospital. He had a 10/24/22 care plan problem of a resident to resident altercation. He had put both hands around another resident's neck. The interventions had included to have the resident placed on 15 checks to ensure safety or one-to-ones as needed, as directed by immediate supervisor on duty. During an interview, on 12/1/22 at 12:38 p.m., the Director of Nursing indicated the resident had originally admitted to the facility from an inpatient psychiatric hospital and had several inpatient stays since. On 10/22/22 staff had heard a noise and responded to find him in Resident 23's room, with his hands around Resident 23's neck. He was placed on one-on-one until the ambulance arrived to transport him to the emergency room. 2. During an observation, on 11/29/22 at 3:35 p.m., Resident 23 was lying in bed with eyes opened. Resident 23's clinical record was reviewed on 11/29/22 at 4:01 p.m. Diagnoses included, but were not limited to, depression, dementia and anxiety. A 10/3/22 annual MDS assessment indicated he had severe cognitive impairment. He required extensive assistance with bed mobility and with transfers and was totally dependent with locomotion on and off the unit. A nurse progress note, dated 10/22/22 at 4:10 p.m., indicated a resident to resident altercation. The note lacked detail of the altercation. A social service progress note, dated 10/23/22, indicated a resident to resident altercation had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 00 B. WING	12/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occurred on 10/22/22 and the resident did not recall the incident. Review of a facility reported incident, dated 10/23/22 at 9:12 a.m., indicated Resident 46 had entered Resident 23's room on 10/22/22, staff responded, and found Resident 46 had both hands around Resident 23's neck. Staff intervened and removed Resident 46's hands. A nurse assessed Resident 23 and no injury had been noted. Review of a current facility policy, titled "ABUSE PROHIBITION, REPORTING AND INVESTIGATION," with a revised date of 9/17 and provided by the Director of Nursing on 12/1/22 at 3:19 p.m., indicated "...This facility shall not permit residents to be subjected to abuse by anyone...." 3.1-27(a)			