| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155526 | A. BUILDING 00<br>B. WING | 10/30/2023 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: October 23, 24, 25, 26, 27, and 30, 2023<br><br>Facility number: 000148<br>Provider number: 155526<br>AIM number: 100275500<br><br>Census Bed Type:<br>SNF/NF: 57<br>Total: 57<br><br>Census Payor Type:<br>Medicare: 12<br>Medicaid: 36<br>Other: 9<br>Total: 57<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on November 6, 2023. | 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 0565<br>SS=E<br>Bldg. 00 | 483.10(f)(5)(i)-(iv)(6)(7)<br>Resident/Family Group and Response<br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Melinda Hodgson | Administrator | 11/17/2023 |

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| | resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>Based on observation, interview, and record review the facility failed to resolve continued Resident Council concerns regarding late mealtimes.<br><br>Finding includes:<br><br>Resident Council minutes were reviewed on 10/23/23 at 2:49 p.m., and indicated the following concerns: | F 0565 | 1 Mealtime monitoring tools were put into place to monitor meal service times. The administrator will meet with the resident council committee to follow up on a monthly basis to assure meals are on time, until resolved. The dietary staff has been re-educated on time management and the importance of timely meal service. The | 11/17/2023 |

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| | 6/21/23 Old Business - Dietary: The mealtimes have not improved on all meals. They get them late frequently.<br>6/21/23 New Business - Dietary: The Council feels the mealtimes have not improved.<br>6/26/23 Resident Council Feedback - Dietary Concerns - The Council feel the mealtimes have not improved. They feel they receive meals later than the scheduled times. Dietary department response - Dietary Supervisor continues to monitor service times and ensures they are on time.<br><br>The feedback notes lacked evidence of formal monitoring of meal times.<br><br>7/24/23 Old Business - Dietary: The mealtimes have not improved.<br>7/24/23 New Business - Dietary: The mealtimes have not improved.<br>8/5/23 Resident Council Feedback - Dietary Concerns - The Council all feel the mealtimes have not improved. Dietary department response - Dietary Supervisor continues to monitor mealtimes. They have been appropriate.<br><br>The feedback notes lacked evidence of formal monitoring of meal times.<br><br>8/23/23 Old Business - Dietary: The mealtimes have not changed.<br>8/23/23 New Business - Dietary: Mealtimes have not improved.<br>8/25/23 Resident Council Feedback - Dietary Concerns - Mealtimes have not improved. Dietary department response - Mealtimes are being monitored.<br><br>The feedback notes lacked evidence of formal monitoring of meal times. | | administrator will monitor resident concerns and follow up to assure timely resolution of grievances.<br>2 Mealtime monitoring tools were put into place to monitor meal service times. The administrator will meet with the resident council committee to follow up on a monthly basis to assure meals are on time, until resolved. The dietary staff has been re-educated on time management and the importance of timely meal service. The administrator will monitor resident concerns and follow up to assure timely resolution of grievances.<br>3 The facility's policy for resolution of grievances has been reviewed with no changes indicated at this time. The Administrator will review all grievances to assure timely follow up and resolution. The administrator and/or her designee will monitor mealtimes 5 days per week at random mealtimes, in order to monitor all meals, x 4 weeks, then 3 x per week x 4 weeks, weekly x 4 weeks and monthly thereafter to assure timely meal service. Should concerns be noted, corrective action shall be taken. In-service education for dietary staff was provided for time management and on time meal service.<br>4 As a means of Quality Assurance, The Administrator will review any findings and | |

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| | 9/18/23 Old Business - Dietary: The meals are still not on time and interfere with activity times and other things.<br>9/18/23 New Business - Dietary: Meals are still not on time.<br>9/21/23 Resident Council Feedback - Dietary Concerns - Council feels mealtimes still run late. Dietary department response - Mealtimes are being monitored. Staff is being educated about the importance of timely meals in the facility.<br><br>The feedback notes lacked evidence of formal monitoring of meal times. The nursing department had an audit of how quickly trays were passed after the carts were delivered to the nursing unit, but did not include times.<br><br>During a meeting with the Resident Council on 10/23/23 at 3:58 p.m., four of the six residents in attendance indicated meals were often late. They sometimes did not get lunch until after 1:30 p.m. With the meals being served late, it ran into their scheduled activities. It was not getting any better.<br><br>Review of facility mealtimes, provided by the DON on 10/23/23 at 2:00 p.m., indicated they had been updated on 6/23/23. Mealtimes were as follows: Breakfast was at 7:30 am for the North Hall Cart, 8:00 a.m. for the West Dining Room and 400 Hall Cart, 8:15 a.m. for the 100 Hall Cart, 8:25 a.m. for the 300 Hall Cart, and 8:30 a.m. for the 500 Hall Cart. Lunch was at 12:00 p.m. for the North Hall Cart, 12:30 p.m. for the West Dining Room and 400 Hall Cart, 12:45 p.m. for the 100 Hall Cart, 12:55 p.m. for the 300 Hall Cart, and 1:00 p.m. for the 500 Hall Cart.<br><br>During an interview on 10/24/23 at 11:41 a.m., Resident 4 indicated they sometimes got their | | subsequent corrective actions taken; reporting to the facility's 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. | |

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| | lunch at 1:45 p.m. which caused them to have to hurry to eat so they could attend bingo at 2:30 p.m. This was one of the activities they did not want to miss.<br><br>During an observation on 10/25/23 at 8:58 a.m., the 500 Hall Cart for breakfast was announced.<br><br>During an observation on 10/25/23 at 9:01 a.m. staff began delivering trays to the residents on the 500 Hall with the last tray delivered at 9:09 a.m.<br><br>During an observation on 10/25/23 at 12:16 p.m., the North Hall cart was announced.<br><br>During an observation on 10/25/23 at 12:18 p.m., the staff began passing the trays on the North Hall.<br><br>During an observation on 10/25/23 at 1:16 p.m., the lunch meal cart was delivered to the 300 Hall.<br><br>During an observation on 10/25/23 at 1:20 p.m., the lunch meal cart was delivered to the 500 Hall.<br><br>During an observation on 10/25/23 at 1:26 p.m., the last lunch tray on the 500 Hall was delivered to room 509.<br><br>During an observation on 10/25/23 at 1:28 p.m., the last lunch tray on the 300 Hall was delivered to room 317.<br><br>During an interview at 10/26/23 at 2:53 p.m., the Dietary Manager indicated since she had become the dietary manager, staffing had been good, but the last month had been rough.<br><br>During an interview at 10/30/23 at 4:45 p.m., LPN 13 indicated several months ago, breakfast arrived | | | |

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| | in the main dining room around 9:00 a.m. most mornings. Mealtimes had improved some lately.<br><br>A current facility policy, dated 5/2018 and provided by the DON on 10/30/23 at 4:50 p.m., titled "Meal Hours," indicated "...Policy: Resident meals and snacks are served at regularly scheduled times ...meal times reflect when the residents should receive their meal NOT when dietary should start setting up trays ...."<br><br>A current policy, dated 11/2008 and provided by the DON on 10/30/23 at 4:56 p.m., titled "Resident Council," indicated "...It is the policy of this facility to: ... 9. Distribute to each department a record of the resident' concerns in order to provide assistance and response to request from the council. 10. Indicate, in writing, a response, follow-up, or plan regarding any documented concerns from the resident council meetings. 11. Include in the above responses in the resident council minutes to be read at the next resident council meeting in order to determine resolution ...."<br><br>3.1-3(l) | | | |
| F 0578 SS=D Bldg. 00 | 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed | | | |

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| | medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) 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 resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>Based on interview and record review, the facility failed to ensure a resident's advance directives were consistent in the clinical record, and changes were verified, for 1 of 3 residents reviewed for advance directives (Resident 3).<br><br>Finding includes: | F 0578 | 1 Resident 3's electronic record was updated to correct the accurate code status.<br>2 An audit of all resident electronic records and paper charts was conducted in an effort to identify other residents whose code status might be affected, | 11/17/2023 |

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| | Resident 3's record was review on 10/24/23 at 9:21 a.m. Her diagnoses included hypertension, hypothyroidism, and dementia.<br><br>Her physician's orders included a code status for DNR (do not resuscitate).<br><br>The resident's electronic continuity of care document and face sheet indicated "do not resuscitate".<br><br>Her current code status care plan, with the last revision date of 8/31/23, indicated the resident did not want cardiopulmonary resuscitation (CPR).<br><br>The advance directives in the resident's paper chart indicated the resident did not want to have CPR performed as a lifesaving measure. The DNR was signed by the resident's representative on 4/23/21.<br><br>An advance directive in the resident's electronic chart (in the admission agreement) indicated the resident did want to have CPR performed, if needed, as a lifesaving measure. The advance directive was signed by the resident's representative on 1/18/22.<br><br>During an interview, on 10/26/23 at 2:46 p.m., LPN 11 indicated the resident's code status was on the computer main screen for the resident, on the 24-hour sheet, and in the resident's paper chart.<br><br>During an interview, on 10/26/23 at 3:19 p.m., RN 12 indicated she would look at the resident's paper chart in the advance directives section to check if a resident wanted CPR. The code status for a resident was also listed on the 24-hour sheet.<br><br>During an interview, on 10/26/23 at 4:33 p.m., the | | with no findings identified.<br>3 As a means to ensure ongoing compliance, the admission coordinator will consult with the Director of nursing and or her designee, prior to uploading admission documents to assure the accurate code status. This practice will occur with all new admissions x 3 months, and then the Director of Nursing and or her designee will monitor random admission records x 3 months, to assure accurate electronic /paper chart compliance. Should concerns be noted, re-education and/or corrective action shall be taken as warranted.<br>4 As a means of Quality Assurance, The Director of Nursing and or her designee will review any findings and subsequent corrective actions taken: reporting to the facility's 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. | |

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| | DON indicated the admission paperwork had been updated sometime after admission. She was uncertain why the paperwork indicated the resident wanted CPR.<br><br>During an interview, on 10/26/23 at 4:44 p.m., the DON indicated she had spoken with the resident representative about the code status of the resident. The resident representative told the DON she remembered signing papers; she did not really pay attention to the papers she was signing. The DON indicated the advance directives in the electronic chart should have matched what was in the paper chart. When the admission paperwork was signed, the facility verified everything on admission. When the admission paperwork was re-signed, the records were not verified.<br><br>A current policy, dated 1/2015, provided by the DON on 10/30/23 at 4:45 p.m., titled "Advance Directives," indicated " ...When presented with an Advance Directive document, the facility shall verify the attending physician has a copy of the document and shall place a copy of the Advance Directive in the resident's office file as well as on the resident's clinical record at the nursing station ...."<br><br>3.1-4(f)(5) | | | |
| F 0584<br>SS=E<br>Bldg. 00 | 483.10(i)(1)-(7)<br>Safe/Clean/Comfortable/Homelike Environment<br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide- | | | |

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| | §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>Based on observation and interview, the facility failed to maintain toilets in a clean and homelike manner for 3 of 4 residents reviewed for environment (Residents 4, 25, and 52) of the 15 residents who resided on the 500 Unit. | F 0584 | 1 The toilet and flooring in resident 4's bathroom was replaced. Resident 25's toilet has been replaced, resident 52's toilet has been cleaned, and the shower room toilet on the 500 hall has | 11/17/2023 |

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| | Findings include:<br><br>1. During an observation of Resident 4's room, on 10/24/23 at 11:41 a.m., the toilet had a thick black and gray residue in the bottom of the toilet bowl. The residue surrounded the entire opening where contents flushed down the toilet, with black debris along the base of the toilet on the right side where the toilet rested against the floor.<br><br>During an interview on 10/24/23 at 11:41 a.m., Resident 4 indicated the previous Maintenance Director was aware of the black residue on the right side of the toilet at the floor, before the current Maintenance Director started at the beginning of September.<br><br>During an interview on 10/24/23 at 11:54 a.m., a visitor in Resident 4's room indicated the resident's toilet was not kept in a clean manner because the facility was short on housekeeping staff members.<br><br>During a observation on 10/25/23 at 3:58 p.m., Resident 4's toilet remained soiled with black residue inside of the toilet bowl. The black residue along the right side of the toilet at the floor remained unchanged from the previous observation.<br><br>During an observation on 10/27/23 at 10:24 a.m., Resident 4's toilet remained unchanged from the observation on 10/24/23.<br><br>During an interview on 10/27/23 at 10:46 a.m., the Housekeeping Supervisor indicated high-touch surfaces were cleaned daily for infection prevention, which included toilets.<br><br>During an observation on 10/27/23 at 11:19 a.m., | | been replaced, to assure a homelike environment.<br>2 The toilets in all bathrooms have been cleaned to assure a homelike environment. The housekeeping staff have been re-educated on the daily cleaning schedule with special attention to the cleaning of toilets.<br>3 As a means to ensure ongoing compliance, the housekeeping supervisor and or her designee will monitor residents' bathrooms on a daily basis x 4 weeks, 3 x per week x 4 weeks then weekly ongoing to assure toilets are clean and a homelike environment established.<br>4 As a means of Quality Assurance, the Housekeeping Supervisor and or her designee will review any findings and subsequent corrective actions taken: reporting to the facility's 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. | |

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| PERSIMMON RIDGE REHABILITATION CENTRE | 200 N PARK ST<br>PORTLAND, IN 47371 |

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| | the Housekeeping Supervisor indicated the inside of Resident 4's toilet was black and heavily soiled. When they cleaned the toilet bowl, black pieces were loosened and made the water in the toilet black. All of the build up was not entirely removed with one cleaning. It was not re-cleaned. She was able to remove nearly all of the black residue from the right side of the toilet with bleach spray.<br><br>2. During an interview on 10/23/23 at 3:58 p.m., Resident 25 indicated her toilet stool was absolutely gross because the staff were only sweeping and mopping in her room. No one had cleaned her toilet for sometime.<br><br>During an observation on 10/25/23 at 3:47 p.m., Resident 25's toilet contained excessive dark brown/black residue in the bottom on the inside of the toilet bowl. Behind the toilet seat, between the seat and the toilet tank, the toilet rim contained moderate dust/debris. Dried yellow debris was on the front of the toilet, from the toilet seat to the floor, with particles of dust collected in it.<br><br>During an interview on 10/26/23 at 8:35 a.m., Resident 25 indicated her toilet had still not been cleaned. She was uncertain when it was last cleaned because it had been so long. The toilet remained unchanged from the previous observation.<br><br>During an observation on 10/27/23 at 11:25 a.m., the Housekeeping Supervisor indicated Resident 25's toilet was heavily soiled. As she cleaned the toilet bowl, an excessive amount of dark black flakes were loosened from inside the toilet bowl making the water turn black. All of the build up was not entirely removed with one cleaning. It | | | |

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| | was not re-cleaned. The dried yellow debris and dust on the outside was able to be removed during cleaning.<br><br>During an interview on 10/27/23 at 11:25 a.m., the Housekeeping Supervisor indicated the observed toilets were not kept clean and in a homelike manner. This was a result of being short staffed by two team members for the past three to four weeks. The typical staffing for housekeeping was two staff members each day.<br><br>Review of the Housekeeping and Laundry Schedule from 10/22/23 to 11/4/23 indicated the following: no housekeepers were scheduled on 10/22/23, 10/26/23, and 11/4/23, and only one housekeeper was scheduled on 10/25/23, 10/28/23, 10/29/23, 10/31/23, 11/1/23, and 11/3/23. On 10/22/23 and 11/4/23 the Housekeeping Supervisor was scheduled off. From 10/23/23 through 11/3/23 the Housekeeping Supervisor was scheduled to work every day in laundry. On 10/28/23 and 10/29/23, the Housekeeping Supervisor was scheduled to work both days and nights laundry.<br><br>3. During an observation on 10/25/23 at 3:53 p.m., Resident 52's toilet contained dried brown debris scattered about the inside of the toilet bowl. The toilet riser above the toilet contained smeared brown debris on the front of the riser and to the right of center.<br><br>During an interview on 10/27/23 at 10:27 a.m., Resident 52 indicated she thought the facility was short on housekeepers because the bathroom had not been cleaned since last week. They used to clean it more frequently.<br><br>During an interview on 10/27/23 at 11:36 a.m., the | | | |

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| | Housekeeping Supervisor indicated Resident 52's toilet was soiled. All debris was removed from the toilet and riser during cleaning. When she did not have housekeeping staff, there were days she worked a half day in laundry and a half day in housekeeping.<br><br>4. During an observation on 10/26/23 at 10:15 a.m., the 500 Unit Shower Room toilet had moderate black/gray residue inside the toilet bowl.<br><br>During an observation on 10/27/23 at 10:36 a.m., the 500 Unit Shower Room toilet remained soiled.<br><br>During an interview on 10/27/23 at 10:36 a.m., CNA 6 indicated the condition of the toilets in the following rooms were not clean and homelike for residents' use: 500 Unit Hallway Shower, Resident 4's, Resident 25's, and Resident 52's. The 500 Unit Shower was utilized by all 15 residents on the 500 Unit when they needed to use it at shower time. She had toileted residents on the above mentioned toilets, but failed to recognize the unsanitary condition of the toilets.<br><br>During an interview and observation on 10/27/23 at 11:02 a.m., the Housekeeping Supervisor indicated the moderate black/gray debris in the 500 Unit Shower Room toilet was nearly all removed when it was cleaned. Some of the cleaning tasks may not be completed each day as a result of short staffing for housekeeping and laundry.<br><br>During an interview on 10/30/23 at 5:24 p.m., the DON indicated resident rooms and bathrooms should be cleaned on a daily basis.<br><br>A current facility policy, revised on 9/17, titled "RESIDENT RIGHTS," provided by the DON on | | | |

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| | 10/30/23 at 5:15 p.m., indicated the following: "...POLICY: This facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility shall protect and promote the rights of the resident...."<br><br>3.1-19(f)(5) | | | |
| F 0644 SS=D Bldg. 00 | 483.20(e)(1)(2)<br>Coordination of PASARR and Assessments<br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) was submitted for a resident with a new mental health diagnosis (Resident 18).<br><br>Finding includes: | F 0644 | 1 Resident # 18's PASARR was submitted and updated to include new diagnosis.<br>2 All other residents charts will be reviewed to ensure updates of PASAAR were conducted with diagnosis change. | 11/17/2023 |

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| | Resident 18's clinical record was reviewed on 10/26/23 at 3:14 p.m. Diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance (10/3/22), delusional disorders (4/12/22), other recurrent depressive disorders (12/1/20), and generalized anxiety disorder (7/19/22).<br><br>Her current medication orders included sertraline (anti-depressant) 75 mg daily.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 10/9/23, indicated the resident was moderately cognitively impaired. She had an indicator of psychosis with hallucinations. Her active diagnoses included anxiety disorder, depression, and psychotic disorder.<br><br>A care plan, last updated 7/27/23, indicated the resident had hallucinations as evidenced by seeing men in her room and talking to people who were not there.<br><br>A care plan, last updated 7/27/23, indicated the resident suffered from delusions due to delusional disorder and dementia.<br><br>A PASARR Level I screen was completed on 8/7/20. No mental health diagnosis, known or suspected, was listed under the under the mental health diagnoses section. Under the behaviors and symptoms section, the following was indicated: There are no known mental health behaviors which affect interpersonal interactions, there are no known mental health symptoms affecting the individual's ability to think through or complete tasks which she should be physically capable of completing, and there are no known recent or recurrent mental health symptoms. | | 3 As a means to ensure ongoing compliance, the Social Service Designee was re-educated per the PASAAR provider guidelines to assure understanding of submission of PASAAR level 1 screening with any new mental health diagnosis. The Corporate Social Service Consultant or designee will conduct 10 resident record audits monthly to assure proper PASAAR screening guidelines are accurate. Should concerns be noted, re-education and/or corrective action shall be taken as warranted.<br>4 As a means of Quality Assurance, the Social Services Consultant or designee will review any findings and subsequent corrective actions taken; reporting to the facility's 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. | |

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| | Under the mental health medications section, donepezil (for Alzheimer's disease) 10 mg daily was listed. The outcome indicated no Level II was required. The rational indicated the Level I screen indicated that a PASARR disability was not present because of no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occurred or new information refuted these finding, a new screen must be submitted.<br><br>During an interview, on 10/26/23 at 3:52 p.m., the Corporate Social Services Consultant indicated the 8/7/20 was the most recent PASARR for the resident. A new PASARR level I had not been submitted with the addition of the delusional disorder diagnosis.<br><br>During an interview, on 10/26/23 at 4:13 p.m., the Corporate Social Services Consultant indicated the facility did not have a policy for PASARR level l. They followed the PASARR provider guidelines.<br><br>The Maximus Indiana PASARR level l and Level of Care Screening Procedures for Long Term Care Services Provider Manual, with the most recent revision on 4/29/20, accessed on 10/30/23 at 3:49 p.m. at maximusclincalservices.com, indicated the following: " ...The PASRR process must be completed before a person admits and when a person's status significantly changes - referred to as a Status Change review ...Persons with Serious Mental Illness (SMI) The Level l screen gathers information about people with SMIs [severe mental illness] ...The federal definition for SMI is: Diagnosis of a major mental illness, such as schizophrenia, schizoaffective disorder, major depression, psychotic disorder, panic disorder, obsessive compulsive disorder and any other | | | |

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| | disorder that could lead to a chronic disability that is not a primary diagnosis of dementia ....Examples of a mental status change event include: a new mental health diagnosis not listed on previous Level I or Level ll ...." | | | |
| F 0728 SS=D Bldg. 00 | 483.35(d)(1)-(3)<br>Facility Hiring and Use of Nurse Aide<br>§483.35(d) Requirement for facility hiring and use of nurse aides-<br>§483.35(d)(1) General rule.<br>A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless-<br>(i) That individual is competent to provide nursing and nursing related services; and<br>(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or<br>(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).<br><br>§483.35(d)(2) Non-permanent employees.<br>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.<br><br>§483.35(d)(3) Minimum Competency<br>A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual-<br>(i) Is a full-time employee in a State-approved training and competency evaluation program;<br>(ii) Has demonstrated competence through satisfactory participation in a State-approved | | | |

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| | nurse aide training and competency evaluation program or competency evaluation program; or<br>(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).<br>Based on observation, interview, and record review, the facility failed to ensure a nurse aide became certified within four months of completing training for 1 of 4 CNA students reviewed. (CNA 7)<br><br>Finding includes:<br><br>During an interview on 10/26/23 at 10:06 a.m., CNA Student 7 exited a resident's room on the 300 unit after providing care. She indicated she was hired in late April 2023, and continued to work full time for the facility, approximately 36 hours a week. She continued independently with her CNA Student duties each shift, without a CNA certification. She needed to retake her skills test, but she did not have a date scheduled.<br><br>Review of employee records on 10/26/23 at 1:36 p.m., indicated CNA Student 7 was hired on 4/25/23.<br><br>During an interview on 10/30/23 at 5:20 p.m., the Human Resources Director indicated CNA Student 7 completed her CNA classroom and clinical training on 5/18/23. She was not currently certified, but should have been certified within 4 months from her training completion date.<br><br>During an interview on 10/30/23 at 5:27 p.m., the DON indicated she sent an email to the testing entity on 8/2/23 to assist CNA Student 7 to get scheduled for the testing. While CNA Student 7's testing was delayed, she continued to remain full | F 0728 | 1 Aide # 7 was removed from Aide duties and is working under the job description of a “Helping Hand”<br>2 The DON has reviewed all C.N.A. / Aide Staffing to assure staff has completed a training and competency evaluation program approved by the state as meeting the requirements of certification. There were no findings.<br>3 As a means to ensure ongoing compliance, the HR Director, ADON and the DON were re-educated on the requirements of completion of certification for C.N.A.’s and timeframes of such. The HR Director will monitor all C.N.A. Student files weekly to assure certification in a timely manner and assuring removal of the student from aide duties to Helping hand duties until certification is acquired. Should concerns be noted, re-education and/or corrective action shall be taken as warranted.<br>4 As a means of Quality Assurance, the HR Director or designee will review any findings and subsequent corrective actions taken, reporting to the facility’s QA committee on a monthly basis for a minimum of 6 months and | 11/17/2023 |

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| | time in her CNA duties from 9/18/23 until 10/26/23 without a certification. The DON indicated she failed to remove CNA Student 7 from her full time CNA Student position after 9/18/23. The facility lacked a policy regarding CNA Student certification timing. They followed the Indiana State guidelines.<br><br>3.1-14(b) | | the frequency of the monitoring will be increased or decreased if indicated to maintain compliance. | |
| F 0801<br>SS=F<br>Bldg. 00 | 483.60(a)(1)(2)<br>Qualified Dietary Staff<br>§483.60(a) Staffing<br>The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)<br><br>This includes:<br>§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-<br>(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.<br>(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or | | | |

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| | nutrition professional.<br>(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.<br>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.<br><br>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.<br>(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-<br>(A) A certified dietary manager; or<br>(B) A certified food service manager; or<br>(C) Has similar national certification for food service management and safety from a national certifying body; or<br>D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or<br>(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, | | | |

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| | 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and<br>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and<br>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.<br>Based on interview and record review, the facility failed to ensure the dietary manager completed the required education to meet the qualifications for a dietary manager. This deficiency had the potential to affect 57 of 57 residents who received meals from the facility kitchen.<br><br>Finding includes:<br><br>Employee records were reviewed on 10/26/23 at 1:36 p.m. The records lacked documentation of the required certification for the Dietary Manager.<br><br>During an interview, on 10/26/23 at 2:05 p.m., the Human Resources Director indicated the Dietary Manager began functioning in her role as the Dietary Manager on 10/9/22. She did not have any certifications for the Dietary Manager.<br><br>During an interview, on 10/26/23 at 2:16 p.m., the Regional Director of Operations indicated the Dietary Manager had enrolled in a dietary manager training course on 2/20/23 to become a certified dietary manager. He was uncertain when she planned to complete the course.<br><br>During an interview, on 10/26/23 at 2:53 p.m., the Dietary Manager indicated the dietician was not at | F 0801 | 1 The current Dietary Manager has resigned from her position, and we are in the process of hiring a Dietary Manager with the appropriate qualifications.<br>2 No residents have been affected.<br>3 As a means to ensure ongoing compliance, the Administrator will assure a qualified Dietary Manager is in place.<br>4 As a means of Quality Assurance, the Administrator will review any findings and subsequent corrective actions taken; reporting to the facility's 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. | 11/17/2023 |

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| | the facility full time; she visited the facility about every other week. She had been the Dietary Manager for about a year this time and had filled the role in the past for about three years. She did not have any food safety certifications, but was currently enrolled in a dietary manager certification program.<br><br>An undated policy, titled "410 IAC 16.2-3.1-20 Dietary services" provided by the Corporate Nurse Consultant on 10/30/23 at 5:40 p.m., indicated " ...The food service director must be one (1) of the following: (1) A qualified dietitian. (2) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year experience in some aspect of institutional food service management ...."<br><br>The Indiana Department of Health Long-term Care Newsletter, dated 10/26/23, retrieved from https://www.in.gov/health/ltc/contact/newsletters / on 10/30/23 at 2:02 p.m., indicated the following Dietary Manager Qualifications: " ...Effective Oct. 1, the Centers for Medicare and Medicaid Services requires the following qualifications for the director of food and nutrition services under F801 of the State Operations Manual, §483.60(a)(2). "If a qualified dietitian or other clinically qualified nutrition professional is not employed fulltime, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or (D) Has | | | |

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| | 155526 | A. BUILDING 00<br>B. WING | 10/30/2023 |

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

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| | an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving" Certification from ServSafe, or similar national certification for food service management and safety from a national certifying body, meets the requirement for option C, §483.60(a)(2(i)(C). Successful completion of the ServSafe food manager program (or other nationally recognized course of study in food safety and management) by Oct. 1 AND two or more years of experience as a director of food and nutrition services in a nursing facility setting, meets the regulatory requirement of the option E, described in §483.60(a)(2(i)(E) ...."<br><br>3.1-20(h) | | | |
| F 0883<br>SS=D<br>Bldg. 00 | 483.80(d)(1)(2)<br>Influenza and Pneumococcal Immunizations<br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 | | | |

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| | annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side | | | |

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| | effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>Based on record review and interview, the facility failed to offer and/or provide updated pneumococcal immunizations based on current Center for Disease Control (CDC) guidelines for 2 of 5 residents reviewed for infection control. (Residents 4 and 8)<br><br>Findings include:<br><br>1. The clinical record for Resident 4 was reviewed on 10/25/23 at 10:50 a.m. Diagnoses included chronic diastolic congestive heart failure, diabetes mellitus, hypertensive chronic kidney disease, and atherosclerosis of native arteries of extremities with intermittent claudication.<br><br>The resident had a historical administration of Prevnar 13 (pneumococcal immunization) on 3/18/16 and lacked any additional pneumococcal doses. The resident was last offered and refused a pneumococcal immunization on 8/5/20, during admission.<br><br>2. The clinical record for Resident 8 was reviewed on 10/25/23 at 11:17 a.m. She admitted to the facility on 10/26/20. Diagnoses included Type 2 diabetes mellitus with chronic kidney disease, unspecified dementia, hypertension, hypothyroidism, and peripheral vascular disease.<br><br>The resident received Pneumovax 23 (pneumococcal immunization) on 10/2012 outside of the facility. She received Prevnar 13 on 12/14/17. She had not been offered, nor received, any additional doses. | F 0883 | 1 Residents' 4 and 8 have been offered, educated, received or refused if indicated the proper pneumococcal vaccinations per CDC recommendation.<br>2 All resident records have been reviewed. New consents have been obtained to assure resident immunizations are offered, educated, received or refused the most current pneumococcal immunizations based on CDC recommendations.<br>3 As a means to ensure ongoing compliance, the ADON and or her designee will monitor resident's records weekly ongoing to assure resident immunizations are offered, educated, received or refused the most current pneumococcal immunizations based on CDC recommendations.<br>4 As a means of Quality Assurance, the ADON will review any findings and subsequent corrective actions taken; reporting to the facility's 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. | 11/17/2023 |

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| | During an interview on 10/30/23 at 11:50 a.m., the ADON indicated the above mentioned residents had not been offered, educated, received, or refused the most current pneumococcal immunizations based on CDC recommendations. She had been offering this to new admissions, and should have offered and provided pneumococcal education based on current CDC recommendations to the above mentioned residents when they were eligible for the next dose. She indicated the facility followed CDC guidelines.<br><br>A current facility policy, reviewed 1/20/23, titled "IMMUNIZATION PROGRAM," provided by the DON on 10/23/23 at 2:00 p.m., indicated the following: "...PROCEDURE: 1. The facility will attempt to obtain informed consent from the resident or the resident's legal representative... 4. The facility will administer immunizations in accordance with recommendations established by the Centers for Disease Control and Prevention in effect at the time the immunization is administered...."<br><br>3.1-18(b)(5) | | | |