STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Regional Rehabilitation	255 Meadow Dr Danville, IN 46122

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident, (Resident 94) had the right to formulate an advanced directive for 1 of 2 residents reviewed for advance directives. Findings include: On 06/19/25 at 11:44 a.m., Resident 94's medical record was reviewed. He was a long-term care resident with diagnoses which included, but was not limited to, peripheral vascular disease (PVD), a below the knee amputation of his left leg, surgical wound failure with necrosis, and dementia with unspecified severity. At the time of his admission, on 1/14/25, there was no Power of Attorney (POA) and/or guardianship documentation. Resident 94's face-sheet contact information was reviewed and revealed he was his own responsible party and received his Accounts/Receivable (AR) statements. Resident 94's family member was listed as an emergency contact. A social service progress note, dated 4/7/25 at 2:14 p.m., indicated a notary was scheduled to come to the facility to assist Resident 94 to establish a healthcare POA and the family is planning to change code status . son will be at the facility later today to make/discuss plans A social service progress note, dated 4/7/25 at 6:23 .m., indicated Resident 94's son came in to discuss POST form . Writer reviewed options with son. Son stated his wishes were for Resident to become DNR [do not resuscitate] with comfort measures in place. Post form signed Resident 94 had a significant change Minimum Data Set (MDS) assessment, dated 3/24/25, after his BKA. At the time of his assessment he was interviewed, and scored an 11 of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was only moderately cognitively impaired. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/25 at 2:05 p.m., the Administrator (ADM) provided a copy of Resident 94's POA paperwork. The document was titled, Medical Power of Attorney, and was signed/sealed by a Notary Public on 4/7/25. The document indicated, .Even after you sign this document, you will be able to make your healthcare decision assuming you are still considered mentally competent. Your agent cannot act on your behalf until your physician has determined that you are no longer physically or mentally able to make medical decisions unless otherwise stated in this document . Duration: unless stated otherwise [NAME], this document shall remain in effect until I revoke it. I understand that I cannot revoke this document if I am considered incompetent to make my own decision . When My Agent's Authority Becomes Effective: . The only option for initial of acknowledgement of when the agent's authority was to become effective stated: Immediately to make health care decision on my behalf. The election for this option was left blank and was not initialed by the Resident. The document was signed by both the Resident and his son. Resident 94's POST form was prepared on 4/7/25 and signed by the Resident's son. The record lacked documentation that the physician had determined Resident 94 was incompetent. A Social Service progress note, dated 4/18/25 at 2:25 p.m., indicated that Resident 94's son made the decision to implement comfort measures, but did not specify if the resident assisted in making this decision as well. Resident 94 passed away on 5/14/25. During a confidential interview, it was indicated that Resident 94 was alert and oriented with minimal confusion. His confusion was usually worse in the afternoons or evenings when he was more tired. He remembered most of his daily staff members and engaged in meaningful conversation with staff and residents. He was compliant with care and kept talking about how he wanted to get better. He was alert and aware enough to make his own decision and should have had more say in the end. As soon as they stopped trying to fix his wounds, all decisions went through the son. During a confidential interview, it was indicated Resident 94 was very sweet, alert and oriented. He would have regular and appropriate conversations and understood that his condition was not good but wasn't sure what else they could do about it. The son made the decision not to do more surgery because they didn't want him to go under again. During an interview on 6/23/25 at 9:52 a.m., the Social Service Director (SSD) indicated Resident 94 was moderately cognitively impaired, but was alert and oriented. Most of his confusion was noted later in the evenings but during the morning and into the afternoon, his baseline was alert and oriented to his person, place and time. The SSD indicated, I feel like he did understand that [the severity of his medical condition and imminent demise] because he said things like, 'I've lived a good life.' There had been multiple conversations at bedside about changing his code status but he really didn't want to change his code status. Resident 94 was very hard of hearing, so his son would often have to explain back what was being said. Options for different DNR codes status was explained to the son, who indicated he didn't have a good understanding before that there were as many options for comfort/palliative DNR options, and after those options were explained, the son agreed to change Resident 94's code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/25 at 2:05 p.m., the ADM provided a copy of current, but undated facility policy titled, Your Rights and Protections as a Nursing Home Resident. The policy indicated, .at minimum, Federal law specified that nursing home must protect and promote the following rights of each resident: You have the right to: . to create advance directives (a health care proxy or power of attorney, a living will, after-death wishes) in accordance with State Law On 6/20/25 at 2:05 p.m., the ADM provided a copy of current facility policy titled, Advance Directive (POST, DNR, Health Care Rep), revised 7/2023. The policy indicated, .if the resident has capacity to make decision, the resident makes decision regarding their medical decision, advance directives, and healthcare appointments. Resident representatives, health care representatives and/or Power of Attorney should only make decisions when a resident no longer has capacity to make decisions on their behalf. The attending physician determines capacity of the resident to made decision; this assessment should be documented in the medical record 3.1-4(f)(7)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observations, record reviews, and interviews, the facility failed to accurately code the Minimum Data Set (MDS) for a suprapubic catheter (a hollow tube inserted through the abdomen into the bladder to drain urine, typically used when a urethral catheter is not feasible or desirable) and an coded an anticoagulant medication when the resident did not received an anticoagulant medication for 2 of 7 resident reviewed (Residents 39 and 13). Findings include: 1. On 6/19/25 at 9:54 a.m., a record review was completed for Resident 39. She had the following diagnoses which included but were not limited to dementia, hypertension, anxiety, and high cholesterol. Her MDS was not coded as her having a suprapubic catheter. She had an order, dated 5/5/25, for suprapubic catheter, size 18 French (FR), 30 milliliter (ML) bulb. She had an order, dated 5/5/25, to change suprapubic catheter and urinary collection bag as needed for dislodgement, leakage, or occlusion. She had a care plan, dated 5/7/25, that she required assistance with toileting due to assistance with transfers, hygiene, adjusting, catheter care. She had a care plan, dated 5/7/25, indicating she was at risk for falls related to catheter tubing. 2. On 6/19/25 at 11:38 a.m., a record review was completed for Resident 13. She had the following diagnoses which included but were not limited to multiple sclerosis (MS) (a chronic, often disabling disease that attacks the central nervous system, specifically the brain and spinal cord), depression, weakness, and major depressive disorder. Her MDS was coded that she took an anticoagulant medication. She was not prescribed an anticoagulant medication. On 6/19/25 at 1:46 p.m., the Executive Director (ED) provided a corrected copy of Resident 39's MDS. On 6/19/25 at 2:05 p.m., the ED provided a corrected copy of Resident 13's MDS and indicated the MDS coordinator inadvertently coded the wrong type of medication. A document from the RAI (Resident Assessment Instrument) manual, chapter 3 provided by the ED on 6/18/25 at 1:37 p.m. It indicated, .To facilitate accurate resident assessment using the MDS, each section is accompanied by screenshots, which display the item from the MDS 3.0 item set

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review, the facility failed to prevent the potential for accidents with ongoing safety monitoring and assessments for a resident (Resident 62) who required the use of a seat belt in his wheelchair for 1 of 1 resident reviewed for the use of a seat belt. Findings include: On 6/19/25 at 11:41 a.m., Resident 62 was observed seated in his wheelchair (wc). A seat belt was observed across his lap but hung slack to the middle of his thighs. The left side of the belt was frayed nearly in half, as it appeared to rub against a sharp edge of the wc frame. On 6/20/25 Resident 62 was observed multiple times seated in his wc outside of the Activity Director's office door as he visited with staff and other residents. A seat belt was observed across his lap but hung slack and reached almost to the top of his knees. The left side of the belt was observed to rub against a sharp edge of his chair and remained frayed, nearly in half. On 6/23/25 at 9:41 a.m., Resident 62 was observed with the Social Service Director, (SSD). Resident 62 was asked to unbuckle his seat belt, which he demonstrated with ease, however he could not re-buckle it on his own. The SSD observed the frayed edge of the belt, and indicated it must have rubbed on the frame and was no longer in good repair. At that time, a Maintenance Staff member passed by and observed the belt. He indicated it needed to be replaced. On 6/20/25 at 1:26 p.m., Resident 62's medical record was reviewed. He was a long term-care resident with diagnoses which included, but were not limited to, cerebral palsy, shaken infant syndrome and intellectual disabilities. There was an initial Adaptive Device Review, dated 7/25/24, which indicated, Seatbelt on wheelchair. Seatbelt to wheelchair due to resident rocking per mom's request. Therapy evaluated and resident is able to remove seatbelt by self. The initial assessment did not specify the type of belt and/or parameters for ongoing assessment of placement, appropriateness and/or function/condition. He had a physician's order, dated 2/10/25, which indicated he could have a wheelchair with seatbelt. The order did not specify the type of belt and/or parameters for ongoing assessment of placement, appropriateness and/or function/condition. A comprehensive care plan, dated 5/15/25, indicated Resident 62 required assistance with activities of daily living (ADLS). An intervention was added on 5/15/24 which indicated he could be up in his wheelchair with a seatbelt. The care plan lacked implementation and/or revision to specify the type of belt and/or parameters for ongoing assessment of placement, appropriateness and/or function/condition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/25 at 2:05 p.m., the Administrator (ADM) provided a copy of current facility policy titled, Adaptive Device Review Policy, revised 2/2020. The policy indicated, .It is the responsibility of the facility IDT team to review adaptive devices initially and on a quarterly basis to ensure the continued need and/or identify a new intervention . adaptive devised that do not meet the definition of a restraint must be reviewed on a quarterly basis by the IDT team to determine continued need . the use of the adaptive devise needs to be addressed in the resident's plan of care and appear on the resident profile 3.1-45(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to store topical creams from medications, keep the medication cart clean, failed to remove expired insulin from use, and failed to date insulin and eye drops for 2 of 4 medications carts observed. Findings include: 1. On [DATE] at 12:04 p.m., the Cottage medication cart was observed. In the cart it was noted that wound gel was being stored next to eye drops and throat lozenges. Resident 197 had an insulin pen, Humalog, in the cart with no date to indicate when it was opened. There were approximately 50 various pills loose in the second drawer of the medication cart. 2. On [DATE] at 12:22 p.m., the Meadows medication cart was observed. In the cart nitroglycerin tablets was being stored with eye drops. Resident 12 had an insulin pen, Lispro in the cart. It was dated for [DATE]. The observations were confirmed by LPN 6 and LPN 8. A policy titled, Storage and Expiration Dating of Medications and Biologicals was provided by the Executive Director (ED) on [DATE] at 1:41 p.m. It indicated, .Topical (external) use medications or other medications should be stored separately from oral medication when infection control issues may be a consideration .The facility should ensure medications and biologicals that 1.) have an expiration date on the label 2.) have been retained longer than recommendations by manufacturer or supplier guidelines, or 3.) have been contaminated or deteriorated are stored separate from other medications until destroyed or returned to the pharmacy or supplier 3.1-25(j) 3.1-25(m) 3.1-25(n)