STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosebud Village	2050 Chester Blvd Richmond, IN 47374

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to ensure nail care and heel protectors were provided and a podiatry visit was completed for 2 of 2 residents reviewed for foot care. (Resident 37 and Resident 56)Findings include:1. a) The clinical record for Resident 37 was reviewed on 7/23/25 at 11:16 a.m. The diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis, congestive heart failure, chronic pain, and osteoporosis. The ADL (activities of daily living) care plan, last reviewed/revised 5/23/25, indicated Resident 37 required assistance and/or monitoring for ADL care. The goal was to have her ADL needs met. An approach was morning care to include dressing, starting 10/6/15. The pressure ulcer/injury care plan, last reviewed/revised 5/23/25, indicated Resident 37 was at risk for skin breakdown due to slightly limited sensory perception, very moist skin, incontinence, chairfast, very limited mobility, and a problem with friction and sheer. The goal was for her to be free from skin breakdown. An approach was for her to wear heel protectors while in bed, starting 8/13/24. The physician's orders indicated for her to wear heel protectors while in bed, every shift, starting 8/13/24. An observation of Resident 37 was conducted on 7/23/25 at 1:21 p.m. She was lying in bed, but she was not wearing any heel protectors. She had on a pair of purple and pink fuzzy socks. An interview was conducted with Resident 37, on 7/23/25 at 1:21 p.m., during the above observation. She indicated she did not remember staff putting anything else on her feet. An observation of Resident 37 was conducted on 7/25/25 at 12:08 p.m. She was lying in bed, but not wearing any heel protectors. She was wearing the same pair of purple and pink, fuzzy socks that she was wearing during the 7/23/25, 1:21 p.m. observation. An interview was conducted with LPN (Licensed Practical Nurse) 5, on 7/25/25 at 12:09 p.m., in the hallway. She indicated CNA (Certified Nurse Aide) 4 could look to see if Resident 37 was wearing heel protectors. An observation of Resident 37 was conducted with CNA 4 on 7/25/25 at 12:10 p.m. Resident 37 was still lying in bed, not wearing heel protectors. CNA 4 asked Resident 37 if it was okay to apply heel protectors. Resident 37 agreed. CNA 4 removed Resident 37's fuzzy socks and left the room to retrieve heel protectors, as Resident 37's blue heel protectors were on top of a wardrobe closet in the room and could not be reached by CNA 4. CNA 4 returned to the room shortly thereafter with a pair of green heel protectors and applied them to (continued on next page)

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 37's feet. The Skin Management Program policy was provided by the Executive Director on 7/25/25 at 1:40 p.m. It indicated, PURPOSE: To promote the prevention of pressure ulcers/injury development; promote the healing of existing pressure ulcers/injuries and prevent development of additional pressure ulcer/injury PROCEDURE FOR WOUND PREVENTION .3. Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors .4. Residents identified at risk for pressure ulcer/injury and those with pressure ulcer/injury will have an individualized care plan developed with specific risk factors and contributing factors including preventative measures. Direct care givers will be notified of the resident specific prevention interventions. 1. b) The ADL care plan, last reviewed/revised 5/23/25, indicated Resident 37 required assistance and/or monitoring for ADL care. The goal was to have her ADL needs met. An approach was morning and evening care to include bathing, dressing, hair combing, and oral care starting 10/6/15. The pressure ulcer/injury care plan, last reviewed/revised 5/23/25, indicated Resident 37 was at risk for skin breakdown due to slightly limited sensory perception, very moist skin, incontinence, chairfast, very limited mobility, and a problem with friction and sheer. The goal was for her to be free from skin breakdown. An approach was to assess and document her skin condition weekly and as needed, starting 5/14/25. The 7/24/25 weekly skin assessment section entitled Foot Care indicated lotion was applied to her feet. The options Bilateral feet are warm/dry with intact skin. Nails are trimmed. No reddened or discolored areas noted, and Podiatry referral made, were not check marked as having applied to this weekly skin assessment. An observation of Resident 37 was conducted with CNA 4 on 7/25/25 at 12:10 p.m. Resident 37 was lying in bed. CNA 4 removed Resident 37's socks to apply heel protectors to Resident 37's feet. Resident 37's right foot had four very long toenails, three of which curved over the ends of her toes. CNA 4 indicated nursing or podiatry was responsible for trimming her toenails. The most recent podiatry note, dated 2/24/25, indicated the reason for the visit was atherosclerosis of the extremities with increased risk of infection and routine foot care. Podiatric diagnoses were atherosclerosis of the extremities, pedal edema, hammertoes, xerosis, and onychomycosis (nail fungus). The progress notes section indicated, debride nail(s) to patient tolerance, and Non-professional treatment is hazardous to the patient. The next visit was to be as medically necessary but no sooner than 60 days. There were no subsequent podiatry visits in Resident 37's clinical record after the 2/24/25 note. An observation of Resident 37's feet was conducted with the ADON (Assistant Director of Nursing) on 7/25/25 at 12:27 p.m. An interview was conducted with the ADON at that time. The ADON uncovered the blanket from Resident 37's feet and observed her right foot. The ADON indicated nursing could definitely provide some care around her right toes area. This was something nursing was supposed to notice and address during weekly skin assessments, as nursing could provide foot care in between podiatry visits. 2. The clinical record for Resident 56 was reviewed on 7/28/2025 at 11:45 a.m. The medical (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses included schizophrenia and diabetes. A Quarterly Minimum Data Set (MDS) assessment, dated 7/2/2025, indicated Resident 56 was cognitively intact, did not reject care, resident was independent with putting on footwear and personal hygiene. An ADL care plan, last revised 7/11/2025, indicated to assist Resident 56 with hygiene as needed. A physician's order, dated 9/26/2022, indicated Resident 56 may see the podiatrist as needed. A podiatrist note, dated 3/19/2025, indicated Resident 56 to see the podiatrist as medically needed, but no sooner than 60 days. During an observation and interview on 7/22/2025 at 1:30 p.m., Resident 56 indicated they had long toenails. Resident 56 stated, . I haven't had my toenails trimmed in a few months. I am not sure why the podiatrist hasn't seen me. During an observation and interview on 7/28/2025 at 1:45 p.m., Resident 56 indicated they had long toenails. Registered Nurse (RN) 2 verified Resident 56's toenails were long and stated he was not sure the last time she was seen by the podiatrist. During an interview on 7/28/2025 at 2:05 p.m., the Director of Nursing (DON) indicated nursing staff was responsible for nail care, such as trimming nails for residents without complications or making referrals to podiatry for residents with medical complications, such as diabetes. A template nursing assessment entitled, ASC Weekly Skin and Vital Sign Assessment, was provided by the Executive Director on 7/29/2025 at 11:40 a.m. The assessment indicated to . trim nails as needed or make podiatry referral. 3.1-47(a)(7)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure an indwelling catheter drainage bag was free of the contact with the floor for 1 of 2 residents reviewed for urinary catheter usage. (Resident 86)Findings include: The clinical record for Resident 86 was reviewed on 7/28/2025 at 1:05 p.m. The medical diagnoses included cerebral palsy and neurogenic bladder.A Quarterly Minimum Data Set assessment, dated 7/3/2025, indicated Resident 86 was cognitively intact, does not refuse care, was dependent on toilet hygiene and was partially to moderately dependent on assistance from staff for personal hygiene, and utilized an indwelling catheter. A urinary catheter care plan, last revised on 7/16/2025, indicated interventions for Resident 86's indwelling urinary catheter to not allow tubing or any part of the drainage system to touch the floor.A physician's order, dated 9/29/2021, indicated for Resident 86 to utilize an indwelling urinary catheter.During an observation on 7/22/2025 at 1:15 p.m., Resident 86 was laying in bed, and her indwelling urinary catheter bag drainage system was noted contacting the floor.During an observation on 7/28/2025 at 1:20 p.m., Resident 86 was laying in bed, and her indwelling urinary catheter bag drainage system was noted contacting the floor.During an interview and observation on 7/28/2025 at 1:30 p.m., Resident 86 was laying in bed, and her indwelling urinary catheter bag drainage system was noted contacting the floor. Registered Nurse 2 indicated the indwelling urinary catheter drainage bag should be free of the contact with floor and obtained a basin to prevent contact.A policy entitled, Nursing Department Infection Control, was provided by the Executive Direction on 7/29/2025 at 10:30 a.m. The policy indicated, .Urinary drainage bags should have a barrier such as a urinary drainage bag cover or a wash basin underneath them to prevent catheter bags or tubing from touching the ground.3.1-41(a)(2)

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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. Based on observation, interview, and record review, the facility failed to ensure appropriate storage of a medicated cream for 1 or 3 residents reviewed for medication administration. (Resident 86)Findings include:The clinical record for Resident 86 was reviewed on 7/28/2025 at 1:05 p.m. The medical diagnoses included cerebral palsy and neurogenic bladder.A Quarterly Minimum Data Set assessment, dated 7/3/2025, indicated Resident 86 was cognitively intact, does not refuse care, was dependent on toilet hygiene and was partially to moderately dependent on assistance from staff for personal hygiene, and utilized an indwelling catheter. A physician's order, dated 9/29/2021, indicated Resident 86 to use a medicated cream routinely for pain control. During an observation on 7/22/2025 at 1:15 p.m., Resident 86 was laying in bed, and a tube of medicated prescription cream was noted to be on the over bed table. Resident 86 indicated staff leave the tube there and do not always administer it, so she will put it on her knees and hips.During an observation on 7/28/2025 at 1:20 p.m., Resident 86 was laying in bed, and a tube of medicated prescription cream was noted to be on the over bed table.During an interview and observation on 7/28/2025 at 1:30 p.m., Resident 86 was laying in bed, and a tube of medication prescription cream was noted to be on the over bed table. Registered Nurse 2 verified the tube of prescription medicated cream should be stored in the treatment cart and was unsure why it was in Resident 86's room.A policy entitled, Medication Storage and Expiration Policy, was provided by the Executive Direction on 7/29/2025 at 10:30 a.m. The policy indicated, . Medications including treatment items should be stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.3.1-25(m)