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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Bean Blossom Health Care Center	5911 State Road 46 Ellettsville, IN 47429

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 38312 Based on interview and record review, the facility failed to ensure the resident's representative was informed of the baseline care plan for 1 of 1 residents reviewed for mood and behavior. (Resident 56) Finding include: On 7/11/24 at 10:15 a.m., Resident 56' clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety, and insomnia. His admitted was 6/6/24. Resident 56's Interim 48 hour baseline care plan was started on 6/6/24. The clinical record lacked documentation of the resident's representative being informed of the baseline care plan. During an interview on 7/12/24 at 10:24 a.m., the Social Service Designee (SSD) indicated when a new admission was admitted , the facility would have a 72 hour care plan with the family to go over the baseline care plan. During an interview on 7/12/24 at 11:44 a.m., the SSD indicated the clinical record lacked documentation of the 72 hour care plan meeting with family. On 7/12/24 at 11:59 a.m., the Regional Operational Support provided the the facility policy, Resident/Family Participation - Assessment/Person Centered Care Plans, revision date of 4/2017, and indicated it was the policy currently being used. A review of the policy indicated, .5. After baseline care plan is developed a care conference will be held with the resident/representative within 72 hours of admission .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 34848 Based on interview and record review, the facility failed to ensure staff completed a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, and a post-discharge plan of care developed with the participation of the resident for 1 of 1 resident reviewed for discharge. (Resident 58) Findings include: On 7/11/24 at 11:34 a.m., Resident 58's clinical record was reviewed. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, bipolar II disorder, major depressive disorder, anxiety, abnormalities of gait and awareness, cognitive communication deficit, sleep disorder, dysphagia (difficulty swallowing foods or liquids), and need for assistance with personal care. A 4/17/24 discharge Minimum Data Set (MDS) assessment indicated the resident required supervision for self care and ambulation. A review of the resident's progress notes indicated the following: - On 4/10/24 the resident notified the social worker she was going to discharge to Missouri on 4/17/24 at 5:00 p.m. She would go home without home health care or services because she was going out of state. - On 4/17/24 at 3:40 p.m., the resident came to the social worker and asked for her money from the safe. The Assistant Director of Nursing and social worker gave her the money. - On 4/17/24 at 3:55 p.m., a Discharge note on the resident indicated she was a DNR (do not resuscitate). She was given a Brief Interview for Mental Status (BIMS; an assessment used to evaluate a patient's cognitive state) and had no cognitive impairment. She was given the Patient Health Questionnaire (PHQ; a self-report inventory that helps diagnose and screen for mental health disorders) and scored a 0. She has had no behavior or psychosis. She planed to return to Missouri with family. Her medication was called into a local retail pharmacy. Her discharge plans were to leave the state. - On 4/17/24 at 7:15 p.m., the resident left the facility with family and all belongings. No other documentation was located in the resident's clinical record in regard to her discharge from the facility. During an interview on 7/11/24 at 2:45 p.m., the Social Services Director (SSD) indicated she was responsible for discharge services and nursing was responsible for medication reconciliation. She indicated staff should complete the Discharge Summary page prior to a resident's discharge. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 2:56 p.m., the SSD indicated she was unable to locate the completed discharge summary, including a recapitulation of stay in the resident's clinical record. She believed it was because the facility was in between two systems when the resident discharged from the facility, however, it should have been completed. On 7/12/24 at 12:01 p.m., the Director of Nursing provided the facility policy, Discharge Planning Process, dated 1/10/18, and indicated it was the policy currently being used. A review of the policy indicated, . 10. For anticipated discharges, Social Services or designees will invite the resident and/or resident's representative(s) . to a Discharge Care conference(s) prior to the resident's discharge from the facility . The policy did not indicated documentation of a discharge summary or recapitulation of resident stay. 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50647 Based on observation, interview, and record review, the facility failed to provide respiratory care for 1 of 1 residents reviewed. Oxygen tubing was not changed. (Resident 18) Findings include: On 7/9/24 at 12:35 p.m., Resident 18 was observed lying in bed with oxygen (O2) being administered via nasal cannula (NC) at 2 liters (L). The nasal cannula was dated 6/8/24. On 7/10/24 10:40 a.m., Resident 18 was observed lying in bed with O2 being administered via NC at 2 L. The nasal cannula was dated 6/8/24. On 7/10/24 1:18 p.m., Resident 18 was observed sitting in wheel chair with portable oxygen being administered at 2 L via NC, the NC tubing was dated 4/28 (no year indicated). On 7/10/24 2:43 p.m., Resident 18 was observed lying in bed without oxygen on. She indicated she knew she was supposed to wear it at all times but she took it off at times. The NC was lying on the bed next to resident, which was dated for 6/8/24. Resident 18 picked up the tubing and placed in her nose at that time. The NC observed on portable oxygen was dated 4/28. On 7/11/24 9:36 a.m., Resident 18 was observed lying in bed without oxygen on. The NC was lying on bed next to resident, dated for 6/8/24. The NC observed on portable oxygen was dated 4/28. On 7/11/24 12:05 p.m., Resident 18 was observed sitting outside with portable oxygen being administered at 2 L via NC which was dated 4/28. At that time Director of Nursing (DON) indicated tubing was dated for 4/28. On 7/10/24 at 1:54 p.m., Resident 18's clinical record was reviewed. The diagnoses included, but were not limited to, altered respiratory status, history of sleep apnea, myotonic (an inability to relax muscles at will) muscular dystrophy (progressive muscle degeneration, with weakness and shrinkage of the muscle tissue), pneumonia, personal history of pulmonary embolism (a blood clot that develops in a blood vessel elsewhere in the body and travels to an artery in the lung). The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/24, indicated the resident utilized oxygen therapy. The Care Plan, dated 2/2/24, indicated Resident 18 had altered respiratory status. The interventions included, but were not limited to, change, date, and label tubing weekly. The Physician's Orders included, but were not limited to: - Oxygen at 2 liter/minute via nasal cannula to maintain oxygen saturations above 90% every shift (start date 9/10/23). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Date, label, and change oxygen cannula and tubing every seven days, once a day on Saturday (start date 8/17/23). During an interview on 7/11/24 12:05 p.m., with the Director of Nursing (DON), the DON indicated Resident 18 had order for oxygen therapy. The DON indicated nasal cannula tubing was dated 6/8/24, and portable oxygen tubing was dated 4/28. The DON indicated tubing dates were outdated and should have been changed weekly on Saturdays. On 7/12/24 at 10:00 a.m., the DON provided the facility policy, Oxygen Administration, dated 3/30/20, and indicated it was a policy currently being used. A review of the policy indicated, .5. Assure humidifier (as applicable) and oxygen tubing is changed every 7 days, unless otherwise required by manufacturer or state regulation . 3.1-47(a)(6)

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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. 38312 Based on observation, interview, and record review, the facility failed to label a vial (glass container for holding liquid medication) with the opened date for 1 of 2 medication rooms observed. Findings include: On 7/12/24 at 9:20 a.m., the refrigerator in the medication room was observed to have vial of Tubersol (a solution to aid in diagnosis of tuberculosis infection) in a box. The vial and the box lacked an opened date. The Director of Nursing (DON) could not find an opened date, and all opened vials should have an opened date on them. On 7/12/24 at 9:45 a.m., the DON provided the facility's policy, Determining Expiration Dates, undated and indicated it was the policy being used by the facility. A review of the policy indicated .Tubersol/Aplisol .30 days once opened (Refrigerated) . 3.1-25(j)