

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Persimmon Ridge Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 200 N Park St Portland, IN 47371	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>42685</p> <p>Based on record review and interview, the facility failed to ensure a cognitively impaired resident was free from staff-to-resident verbal abuse and physical abuse resulting in a skin tear for 1 of 3 residents reviewed for abuse. (Resident B) The deficient practice was corrected on 2/24/25, prior to the start of survey, and was therefore past noncompliance.</p> <p>Finding includes:</p> <p>Review of a facility reported incident, dated 2/18/25 at 10:30 p.m., indicated the following: Brief Description of Incident: On 2/18/25 the DON and Administrator were notified of allegations of abuse to Resident B during a transfer. CNA 3 was suspended pending an investigation. Preventative measures taken included: a resident assessment per the abuse policy and all alert and oriented residents and all staff members were scheduled for interviews. A follow up on 2/24/25 included the following: During an abuse investigation it was noted that there were two witnesses present during the interaction between the resident and CNA 3. The two witness interviews indicated CNA 3 wanted the resident to go to bed when the resident was not ready to go to bed. CNA 3 failed to follow the plan of care for two staff member assistance with transfers when she assisted the resident to bed by herself. During the transfer, the resident bit CNA 3 in the chest. CNA 3 stated, bite me again, I will bite you back, I'll go to jail I don't care. A skin tear was noted on the resident's arm after the transfer was completed. CNA 3 was terminated upon completion of the abuse investigation.</p> <p>Resident B's clinical record was reviewed on 4/15/25 at 12:20 p.m. Diagnoses included unspecified dementia with other behavioral disturbance, other specified anxiety disorders, recurrent depressive disorders, generalized muscle weakness, and unsteadiness on feet.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/21/25, indicated the resident's cognition was severely impaired. Behaviors included disorganized thinking. The resident used a walker and wheelchair for mobility. He was dependent on staff assistance for toileting and transfers. The resident required maximum assistance from staff for personal hygiene, lower body dressing, and showers.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155526
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current care plan, dated 11/21/24, indicated the resident had physical behavioral symptoms directed toward others such as hitting, kicking, pushing, scratching, grabbing, and biting. Interventions included the following: do not begin care with any signs/symptoms of agitation, allow the resident to calm and then reapproach, stop care and ensure safety if the care has started and the resident becomes combative, allow the resident to calm down, talk to the resident throughout care to establish trust and reassurance, and speak slowly in a calm voice.</p> <p>A current care plan, dated 2/4/25, indicated the resident required up to two staff members for assistance with activities of daily living (ADL) due to impaired cognition and impaired balance and mobility. Interventions included the following: provide assistance with ADL as required and allow the resident to choose their own bed time and assist to bed.</p> <p>A current care plan, dated 11/21/24, indicated the resident had a diagnosis of depression. Interventions included provide reassurance and comfort as needed.</p> <p>A current care plan, dated 11/21/24, indicated the resident had a diagnosis of anxiety. Symptoms may include restlessness, irritability, racing thoughts, excessive worry, fear, and poor concentration. Interventions included ensure a calm environment.</p> <p>A skin assessment, dated 2/18/25 at 9:00 p.m., indicated a skin tear was noted to the resident's left wrist after a mobility transfer. The skin tear measured 1.0 centimeter (cm) long by 1.0 cm wide. The physician was notified on 2/18/25 at 9:10 p.m. The legal representative was notified on 2/18/25 at 10:45 p.m. The resident's range of motion was per usual. The resident denied any pain at the time of the assessment.</p> <p>A nurse's note, dated 2/18/25 at 10:35 p.m., indicated after a mobility transfer, a skin tear was noted on the resident's posterior left wrist with the skin separated. The physician, DON, and resident representative were updated.</p> <p>A skin assessment, dated 2/20/25 at 6:00 a.m., indicated the skin tear to the left posterior wrist was left open to air with no signs or symptoms of infection. New bruising surrounded the wound and measured 23 cm long by 9 cm wide.</p> <p>A review of the facility investigation file, provided by the Administrator on 4/15/25 at 3:40 p.m., included the following information:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A handwritten statement from QMA 4, dated 2/18/25, indicated when Resident B's light was activated on 2/18/25, QMA 4 and CNA 5 answered it. CNA 3 told them she was going with them. They knocked on the door, entered the resident's room, asked if he was okay, and if he needed anything. CNA 5 went to close the blinds, and the resident started to point at CNA 5. He said, to turn it back on. CNA 3 then started to grab the resident by herself attempting to transfer him out of the chair. The resident kept saying to get off of him. He grabbed the chair and would not let go. QMA 4 said, Maybe just let him stay up for a while. He's not ready to go to bed. CNA 3 did not listen and continued to grab the resident and then threw him on the bed. During the transfer, the resident bit CNA 3. CNA 3 said, bite me again I'll bite back, I'll go to jail I don't care. As CNA 3 was walking out of the room, she said F*** this, this is uncalled for. CNA 3 indicated she was leaving. QMA 4 and CNA 5 immediately reported to the QMA what had just happened. QMA 4 and CNA 5 checked with the resident to ensure he was okay. He showed them a skin tear he got from the transfer. QMA 4 did not touch the resident or the chair while CNA 3 picked up the resident all by herself.</p> <p>A handwritten statement from CNA 5, dated 2/18/25, indicated Resident B's call light was activated on 2/18/25. QMA 4 and CNA 5 got up to answer it when CNA 3 said she would tag along. When they got into his room, CNA 5 had closed the residents blinds for privacy. The resident pointed at CNA 5 and indicated to turn it back on. For a moment, CNA 5 was confused. Then CNA 5 said, I wasn't messing with your heat, I was just closing the blinds. The resident still pointed while CNA 3 cut him off and said, No Sir, we are not pointing fingers in people's faces, that's just rude! The resident got agitated with CNA 3, but calmed down for a moment. CNA 5 then asked the resident if he was ready to get into bed. CNA 3 said, He's going to bed. She tried to transfer him to the bed like a bear hug, but he grabbed onto the wheelchair. This brought the wheelchair off of the ground with them, so she sat him back down. QMA 4 said, We can just keep him up, he's not ready for bed. CNA 3 did not listen and proceeded to try to transfer him again. The resident yelled get this man off of me! CNA 5 felt CNA 3 was offended by that statement. CNA 5 said, Just leave him be, we can come back later. CNA 3 picked him up and body slammed him into bed. The resident was not all the way in bed, so CNA 3 lifted him up again to move him back up. CNA 3 yelled, He bit me! The resident began rambling something, but CNA 5 was unable to understand what he said. CNA 3 said, Bite me again I'll bite you back, I'll go to jail I don't care! CNA 3 looked at QMA 4 and said, F*** this, this is f***ing uncalled for. CNA 3 stormed out of the room still cursing and said, She's f***ing leaving. CNA 5 and QMA 4 stayed in the room with the resident after CNA 3 stormed out. When QMA 4 asked the resident if he was okay, he lifted up his arm and said, Look what that man did to me. That was when CNA 5 and QMA 4 saw the resident's skin tear. Another aide walked in and CNA 5 sent them to get QMA 6 immediately. CNA 3 was the only staff member who touched the resident during the transfer. CNA 5 held the wheelchair for a second. When the resident began fighting CNA 3, CNA 5 let go and said, Just leave him be, we can come back later.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A printed text statement from CNA 3, dated 2/18/25 at 11:43 p.m., indicated Resident B had the call light on. CNA 3 offered to assist whichever of the two girls wanted to go, as she usually helped transfer heavier patients due to being tall and strong. All three of them approached the resident's room together. The resident was clearly upset and already yelled at CNA 5 who was on the left side. QMA 4 was on the right side and adjusted the bedding for the transfer. The resident was usually combative during care, especially during transfers or peri care. Originally CNA 5 and QMA 4 were going to use two assist, but this did not work. Since CNA 3 was strong, CNA 3 suggested that QMA 4 hold the chair, and CNA 5 assist with the brief and pants during the transfer. At the same time, CNA 3 supported the resident's back and completed the transfer herself by lifting with her knees. Upon doing this, the resident was combative and threw punches as usual. For the first time, the resident bit CNA 3's left breast. The resident was eased back into the wheelchair and advised that biting was not acceptable and that he needed to be in bed because he had swollen legs. They had a discussion, and QMA 4 suggested letting the resident stay up. Since he needed changed, a second attempt was made with the same set up. Again, the resident resisted and bit CNA 3's breast hard enough it tore the skin. While in mid-transfer to his bed CNA 5 did not have time to remove his pants or brief. QMA 4 had the wheelchair out of the way. The resident was placed on the edge of the bed but was not in a position to be laid down. CNA 3 readjusted him by herself back further onto the bed. Once the resident's feet were up in bed, she mentioned to CNA 5 and QMA 4 that she needed to step out. CNA 5 and QMA 4 remained with the resident to provide care. CNA 3 cursed in pain in the hallway by the service hall. CNA 3 stepped outside with LPN 7 to breathe.</p> <p>A handwritten statement from QMA 6, dated 2/20/25, indicated on 2/18/25 the 300 Unit aides told her that CNA 3 transferred Resident B by bear hugging him. The resident received a skin tear and bit CNA 3.</p> <p>During an interview on 4/15/25 at 3:18 p.m., the Administrator indicated the outcome of the facility investigation determined CNA 3 had been abusive to Resident B on 2/18/25.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 4/15/25 at 4:12 p.m., QMA 4 indicated CNA 3 had been abusive toward Resident B during a transfer on 2/18/25. QMA 4 had worked with CNA 3 in the past but this was the first time she seen her be abusive toward a resident. Between 8:00 p.m. and 10:00 p.m. she had attempted to get the resident in bed for the night, but the resident did not want to go to bed. As a result, QMA 4 and CNA 5 let him remain up in his chair. Later, his call light came on. QMA 4 and CNA 5 were assigned to the resident's unit. They were going to answer the call light, and CNA 3 followed them to the resident's room. They had not requested CNA 3's assistance as she was assigned to a different hallway. When CNA 5 went in the room towards the window, the resident pointed his finger at CNA 5. The resident seemed agitated. When the resident pointed his finger, CNA 3 told the resident not to point his finger at CNA 5. CNA 3 then attempted to pick up the resident from his wheelchair by herself, much like a bear hug. He required assistance of two staff members for transfers. The resident was very agitated and made it known he did not want to go to bed. The resident tried to push CNA 3 away, told her no, and get off of me. When CNA 3 did not stop as the resident requested, he bit her on the chest. Then CNA 3 told the resident, Bite me again. I'll bite back. I'll go to jail. I don't care. QMA 4 tried to tell CNA 3 they should just leave him up in his chair for a while, but CNA 3 continued with the bear hug transfer and threw him into the bed. It was such a struggle, the resident was only halfway into the bed. CNA 3 bear hugged him again to get him the rest of the way into the bed. CNA 3 did this quickly and forcefully. She would not listen to QMA 4, nor the resident's attempts to get her to stop. CNA 3 said, F*** this, while she was still in the resident's room. She stormed out of the room and indicated she was leaving. QMA 4 and CNA 5 stayed with the resident to talk to him calmly since he responded well to calm approaches. When QMA 4 and CNA 5 asked the resident if he was okay, the resident pointed to a new skin tear on his arm and said, look what they done to me. QMA 4 and CNA 5 then saw QMA 6 just outside the resident's door and reported it immediately to QMA 6. It was then reported to RN 8, who notified the DON and the Administrator. She thought CNA 3 had left the building. CNA had not returned to the 300 Unit after she exited the resident's room.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 4/15/25 at 6:44 p.m., CNA 3 indicated she was not a current employee of the facility because she had been terminated for abuse towards Resident B, even though she disagreed with it. On 2/18/25 at approximately 9:30 p.m., she was not scheduled on Resident B's Unit, nor assigned to his care. On 2/18/25 they needed another person to help the other two aides, so CNA 3 entered the resident's room along with QMA 4 and another (unidentified) aide. It was difficult for any staff to provide his care due to his behaviors, but he was cooperative with his family. The resident had dementia and was known to have behaviors. CNA 3 was aware of the following behavior interventions for Resident B: staff were required to approach him in a sweet/calm manner, if he was non-cooperative with care, they were to come back after 15 minutes and reapproach him, and his hat was also used at times for a diversion. QMA 4 and the other aide had attempted to provide care earlier that evening, and the resident refused. They had waited for a period of time and reapproached the resident again. They had not contacted the resident's family to see if they may be able to get a better response from the resident. CNA 3 and the other two aides entered the resident's room. The resident had feces all over him and all over the wheelchair for a very extended period of time and needed to have care. QMA 4 approached the resident first about providing care and the resident was in agreement. QMA 4 and CNA 3 were on each side, and then the resident changed his mind and they put him back down in the wheelchair. CNA 3 and QMA 4 reassessed along with the other aide in the room then they asked to try to transfer him again. CNA 3 was in front of him and lifted him much like a bear hug as she faced the resident, directly in front of him. QMA 4 was behind the wheelchair while CNA 3 did the transfer by herself. When she assisted him to stand, his knees buckled a little, then the resident grabbed her arms and bit her left breast. She sat him down in the chair and said, Sir please don't bite me. CNA 3 then collaborated with the other two aides, and they decided to try one more time with CNA 3 positioned in front of the resident in the same manner doing the transfer, QMA 4 behind the wheelchair. QMA 4 moved the chair and removed the resident's brief but could not complete it because the resident bit CNA 3 again. She lowered, re-emphasized lowered him to the bed by herself. The upper half of his body was on the bed and his feet were off the bed. His bed was in the low position. She told QMA 4 she had to help with his legs. QMA 4, along with the other aide, placed his legs in bed, stayed with the resident, and began providing resident care. As CNA 3 exited the room, she said to the nurse outside the room, Ow what the f*** was that? CNA 3 was unable to identify which staff member was outside the door, but she told them she needed to leave. She went outside and smoked, then returned back into the building and finished her shift. CNA 3 indicated her shift did not end until 1/19/25 at 2:00 a.m. She filled out a behavior note, notified the DON, and provided her statement to the DON that night via text. She was uncertain who notified the Administrator. CNA 3 believed she had not done anything wrong. She was the one who was injured, and her employment was terminated.</p> <p>This information was inconsistent with CNA 3's final timecard punch of 2/18/25 at 9:58 p.m.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/15/25 at 8:44 p.m., CNA 5 indicated she was a witness in Resident B's room when CNA 3 followed CNA 5 and QMA 4 to the resident's room when his call light was activated. The resident was not soiled when they went into the room. CNA 5 and QMA 4 had been in his room and toileted him approximately 30 minutes prior. He had been cooperative with toileting. He was not ready to go to bed when they were in his room before, so they came back and reapproached him after they gave him some time. CNA 5 asked the resident when she entered the room if he was ready to go to bed. He did not respond. She was uncertain if he heard what she said, so she went to the window and closed his blinds so he could get ready for bed. When she closed the blinds, the resident pointed and yelled at her to turn the heat back on. CNA 5 reassured him she did not adjust his heater but instead closed his blinds. CNA 3 interjected, No sir, you are not going to be pointing fingers. That is just rude! QMA 4 asked the resident if he was ready for bed, and he said no. CNA 3 said, Oh, he's going to bed! CNA 3 adjusted the resident's wheelchair closer to the bed and asked CNA 5 to hold onto the wheelchair while she bear hugged him to do his transfer. CNA 5 held onto the wheelchair, and the resident began to yell, Put me down and get this man off of me! The resident held onto the wheelchair as CNA 3 attempted to transfer him by herself. As a result, she was unable to get him fully out of the wheelchair. CNA 5 thought the resident bit CNA 3 on the breast at that time. CNA 3 put the resident back into the wheelchair. CNA 5 let go of the wheelchair, and QMA 4 said, We are going to leave him alone because he does not want to go to bed. CNA 5 reiterated, We are going to leave him alone. Then CNA 3 grabbed the resident's arms, crossed them, and put his arms to his chest in a manner to prevent movement of his arms. CNA 3 picked him up again like a bear hug by herself and, slammed him into the bed. CNA 5 said the bed was slightly lowered when it happened and CNA 3 did not get him fully into the bed. As a result, CNA 3 bear hugged him again to get him repositioned in the bed very forcefully The resident bit CNA 3 again. CNA 3 began to curse and said, Bite me again. I'll go to jail. I don't care. This is f***ing ridiculous! CNA 3 stormed out of the resident's room. resident yelled, Look what that man did to me as he lifted up his left arm sleeve and pointed to a new skin tear with blood on it.</p> <p>During a telephone interview on 4/15/25 at 9:11 p.m., QMA 6 indicated she was assigned to the 300 Unit on 2/18/25, when QMA 4 and CNA 5 notified her of CNA 3's inappropriate bear hug transfer of Resident 6 that resulted in a new skin tear. She immediately entered the resident's room and found his left arm bleeding. The resident typically had behaviors in which he was agitated and yelled at the staff. Since he did not allow her to touch him, she went to get the nurse. The resident should not have been transferred when he expressed he did not want to be transferred.</p> <p>During a telephone interview on 4/15/25 at 9:18 p.m., RN 8 indicated when she arrived at the beginning of her shift on 2/18/25, she replaced QMA 6 on the 300 Unit. Her shift started at 9:00 p.m. QMA 4 and CNA 5 were in the process of reporting what happened with CNA 3 in the resident's room. RN 8 went around and asked some questions of QMA 4, CNA 5, and QMA 6 to obtain more information as she knew this had to be reported immediately to the DON. She assessed the resident who had a skin tear on his left arm with some bleeding. Since the resident would not allow her to immediately address the skin tear, and he had no excessive blood loss, she gave him some time before she came back due to his behaviors. After she collected the information from QMA 4, CNA 5, and QMA 6, and completed the resident's skin assessment, she reported the information to the DON. She was unable to speak with CNA 3, as CNA 3 already clocked out and left the facility by then.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/16/25 at 12:19 a.m., the Administrator indicated the DON notified her of the abuse allegations for CNA 3 on 2/18/25 at 10:30 p.m. They identified they had not been notified timely. With further investigation, they found CNA 5 and QMA 4 had reported an inappropriate transfer resulting in a skin tear, but failed to communication they witnessed abusive behavior to the resident. The resident's skin tear was assessed on 2/18/25 at 9:10 p.m., after CNA 3's transfer of Resident B.</p> <p>During an interview on 4/16/25 at 12:21 p.m., the DON indicated RN 8 notified her of the abuse allegation for CNA 3 on 2/18/25 at 10:30 p.m. She indicated as soon as a staff member was aware of alleged abuse, they were required to immediately protect and secure the resident, immediately remove the staff member from duty, immediately notify the charge nurse, and the charge nurse was to immediately notify the DON and Administrator.</p> <p>A current facility policy, revised 6/2023, titled ABUSE PROHIBITION, REPORTING AND INVESTIGATION, provided by the DON on 4/15/25 at 10:46 a.m., indicated the following: POLICY: This facility shall prohibit and prevent abuse . 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 symptoms. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of a resident, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended in inflict injury or harm . 1. This facility shall not permit residents to be subjected to abuse by anyone, including employees . 2. This facility shall ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source . are reported immediately to the administrator of the facility . IF RESIDENT ABUSE, OR SUSPICION OF ABUSE, IS REPORTED: 1. The resident(s) involved in the incident shall be removed from the situation at once or facility personnel shall remain with the resident to ensure safety. 2. The individual who witnessed the incident or who was informed of the allegation shall immediately notify a charge nurse assigned to the unit on which the resident resides. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty. The nurse shall examine the resident(s) involved to determine whether physical injuries have occurred and their extent. This examination shall be documented in the resident's clinical record. 3. The charge nurse is responsible to notify the facility Administrator and Director of Nursing immediately and to ensure no tampering or destruction of evidence, if applicable. 4. Any facility personnel implicated in the alleged abuse shall be immediately removed from resident care and shall remain suspended until an investigation is completed</p> <p>The deficient practice was corrected by 2/24/25 after the facility implemented a systemic plan that included a facility in-service regarding abuse/neglect/exploitation, responses to catastrophic reactions, staff burnout, and an investigation.</p> <p>This citation relates to Complaint IN00453866.</p> <p>3.1-27(a)</p> <p>3.1-27(b)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>52268</p> <p>Based on interview and record review, the facility failed to timely report allegations of abuse to the appropriate agencies for 1 of 3 residents reviewed for abuse. (Resident B)</p> <p>Findings include:</p> <p>Review of an Indiana State Department of Health facility reported incident, dated 2/18/25 at 11:34 p.m., indicated the facility initiated an investigation for alleged abuse against Resident B. The incident was identified on 2/18/25 at 10:30 p.m. CNA 3 was the staff member involved and suspended pending investigation. Local law enforcement and APS (Adult Protective Services) were not notified. The brief description indicated Resident B was allegedly abused during a transfer.</p> <p>During an interview with the Administrator on 4/15/25 at 3:18 p.m., she indicated she had not notified law enforcement because the resident did not have any serious bodily injury.</p> <p>During a phone interview with QMA 4 on 4/15/25 at 4:12 p.m., she indicated QMA 6 was right outside the room after the incident and she immediately reported it to her, who reported it to RN 8 and subsequently the DON and Administrator.</p> <p>During an interview with the Administrator on 4/16/25 at 9:40 a.m., she indicated she called and suspended CNA 3 on the late evening on 2/18/25 as soon as she was notified. CNA 3 was contacted on her personal phone as she clocked out and left the building for the evening. They received her statement via text the same day.</p> <p>During interview with the Administrator on 4/16/25 at 12:19 p.m., she indicated aides had reported to QMA 6 an inappropriate transfer resulting in a skin tear, but initially did not believe it was abusive until RN 8 questioned them further. The Administrator indicated that was why the employee was not removed immediately and administration was unaware of the alleged abuse until 10:30 p.m. She believed the QMA 4 and CNA 5 were in such shock from what occurred, that communication was delayed. The resident's skin tear was assessed on 2/18/25 at 9:10 p.m.</p> <p>During an interview with the DON on 4/16/25 at 12:21 p.m., she indicated, as soon as they are aware of alleged abuse, staff are to immediately protect and secure the resident, remove the involved employee, and notify the charge nurse, who would notify the DON and Administrator. She indicated the aides should have reported abusive behavior to their charge nurse so Administration would have been notified immediately.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Persimmon Ridge Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 200 N Park St Portland, IN 47371	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, revised 6/2023, titled ABUSE PROHIBITION, REPORTING AND INVESTIGATION, provided by the DON on 4/15/25 at 10:46 a.m., indicated the following: POLICY: This facility shall prohibit and prevent abuse . 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 symptoms. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of a resident, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . 1. This facility shall not permit residents to be subjected to abuse by anyone, including employees . 2. This facility shall ensure that all alleged violations, including mistreatment, neglect or abuse, including injuries of unknown source . are reported immediately to the administrator of the facility. Violations of the aforementioned shall be reported to other officials in accordance with state law through established procedures . IF RESIDENT ABUSE, OR SUSPICION OF ABUSE, IS REPORTED: .7. Local law enforcement shall be notified, if warranted . 14. The Administrator, Director of Nursing, or designee, is responsible to notify the following agencies, as applicable:</p> <p>State Department of Health</p> <p>Adult Protective Services</p> <p>Ombudsman</p> <p>Applicable Licensing Agency</p> <p>Cross reference F600.</p> <p>This citation relates to Complaint IN00453866.</p> <p>3.1-28(c)</p>		