

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 07/31/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by CNA 10 for 1 of 3 residents reviewed for abuse. (Resident C) This deficient practice was corrected on 7/19/25, prior to the start of survey, and was therefore past noncompliance. Findings include: Review of a facility reported incident, dated 7/19/25, indicated CNA 10 took a picture, using her personal cell phone, of Resident C's peri-area. The resident had marked herself with a bingo dauber. The CNA said she took the picture to show to the nurse on duty, but it was later discovered she had shown the picture to multiple staff members. Resident C's clinical record was reviewed on 7/30/25 at 10:03 a.m. Diagnoses included Down syndrome, muscle weakness, osteogenesis imperfecta (a condition where bones are fragile and easily broken), cardiac murmur, obstructive and reflux uropathy, and a cognitive communication deficit. An annual Minimum Data Set (MDS) assessment, dated 6/25/25, indicated Resident C was cognitively intact, did not experience hallucinations, delusions, or behaviors, and was dependent on staff for toileting hygiene, showering, dressing, and all transfers. The resident was unable to walk. A current care plan, dated 7/19/25, indicated Resident C had the potential for fear and anxiety due to an incident on 7/19/25. The goal was Resident C would not exhibit any signs or symptoms of increased anxiety. Interventions included: observe for signs and symptoms of anxiety or depressive symptoms, such as crying, a change in eating or sleeping habits, or isolation, provide one to one care as needed, assess for depression as needed, provide mental health services as ordered, encourage the resident to voice all problems or concerns, be an active listener, and provide reassurance as needed. Staff were to contact the physician and the resident representative upon any significant changes. A current care plan, dated 7/19/25, indicated Resident C required one-on-one care with social services due to an incident on 7/19/25. The goal was the resident would exhibit one positive response during the one-on-one session with social services. Interventions included: services one-on-one to be provided as scheduled, refer to mental health services as needed, notify the physician and resident representative upon any significant change in condition, and observe for signs and symptoms of increased mood or behaviors. A progress note, dated 7/19/25 at 5:00 PM, indicated the Administrator, Director of Nursing (DON), Medical Director, and the resident representative were made aware of the incident that occurred on 7/19/25. A review of the facility investigation, provided by the Administrator on 7/30/25 at 12:58 p. m., included the following: The DON, Administrator, resident representative, Medical Director, and the local Police Department were notified of the incident. CNA 10 was suspended pending further investigation and eventually terminated. The Administrator reported the incident to Adult Protective Services and the local ombudsman on 7/21/25. On 7/19/25, a statement by CNA 10 indicated the following: She was unable to locate the nurse at the time she found resident C with bingo dauber all over her body, including her peri-area. CNA 10 stated she took the picture of the peri-area to show the nurse. She thought she deleted the photo, then found it in her deleted photos after showing another employee. A 7/19/25 statement written by CNA 2 indicated she saw a picture of Resident C on CNA 10's phone at 2:00 a.m. Two pictures were seen; one of Resident C's vaginal area (no face) and a second picture with the resident's hand and part of her face seen. A 7/19/25 statement written by CNA 4 indicated she was sitting at the CNA table with CNA 7, CNA 8, and CNA 10. CNA 10 pulled out her phone and showed them a picture of Resident C's vaginal area, with reddish-pink bingo dauber ink on it. No one said anything after CNA 10 showed staff the picture. A 7/19/25 statement written by CNA 3 indicated she saw a picture of Resident C's vaginal area on CNA 10's phone. Resident C's legs were spread, but her face was not visible. A 7/19/25 statement written by CNA 7 indicated she saw a picture on CNA 10's phone of Resident C from below her belly, but her face was not visible. A 7/19/25 statement written by CNA 8 indicated she was charting at the CNA table when CNA 10 started talking about how she found Resident C with bingo dauber all over her chest, hands, face, upper thigh, and genital area. CNA 10 said she had a picture of it and showed the picture of the resident from her neck down. CNA 8 was shocked by CNA 10's behavior. A 7/19/25 statement written by Qualified Medication Aide (QMA) 6 on 7/19/25 indicated she saw photos of Resident C on CNA 10's phone and CNA 10 told QMA 6 she was going to delete the photos. A 7/19/25 statement written by RN 9 indicated she did not see the photo but heard about it and re-educated CNA 10 to not take pictures of residents and she needed to delete the photo. A 7/19/25 statement written by CNA 5 indicated another employee told her that CNA 10 had a picture of Resident C on her phone and was showing staff. CNA 5 said she saw the picture of the resident while CNA 10 was showing QMA 6. The picture contained Resident C's legs, abdomen, and vaginal area. CNA 5 said</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>(continued on next page)</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>Based on interview and record review, the facility failed to ensure staff immediately reported abuse allegations to the Administrator or designee for 1 of 3 residents reviewed for abuse. (Resident C). This deficient practice was corrected on 7/19/25, prior to the start of survey, and was therefore past noncompliance. Findings include: Review of a facility reported incident indicated CNA 10 took a picture using her cell phone of the resident's peri-area where the resident had marked herself with a bingo dauber. The CNA said she took the picture to show to the nurse on duty, but it was later discovered she had shown the picture to multiple staff members. Resident C's clinical record was reviewed on 7/30/25 at 10:03 a.m. Diagnoses included Down syndrome, muscle weakness, osteogenesis imperfecta (a condition where bones are fragile and easily broken), cardiac murmur, obstructive and reflux uropathy, and a cognitive communication deficit. An annual Minimum Data Set (MDS) assessment, dated 6/25/25, indicated the resident was cognitively intact, did not experience hallucinations, delusions, or behaviors, and was dependent on staff for toileting hygiene, showering, dressing, and all transfers. The resident was unable to walk. During an interview with CNA 7 on 7/31/25 at 12:48 PM, she indicated, around 7:00 or 8:00 p.m. on 7/19/25, during second shift, she and other staff were sitting at a table because they were done with everything. CNA 10 was telling a story about how Resident C had bingo dauber all over her and was making it sound like the resident was touching herself inappropriately with it. CNA 10 thought it was funny and showed everyone the picture. Nobody really said anything. CNA 7 personally did not say anything. CNA 7 did not know if anyone checked on the resident after the picture was taken, because it had happened on the shift before. When the next shift came on, CNA 7 and another CNA mentioned it to the nurse, and at that point, they texted the DON about what had happened. CNA 7 thought it may have been reported to RN 9. The staff received re-education about reporting immediately and if it were to happen again, she would call the Administrator as soon as she saw something inappropriate. During an interview with CNA 8 on 7/31/25 at 12:42 PM, she indicated she saw the pictures in question and was completely stunned. They were all at the CNA table, and CNA 8 was offered to see the pictures. CNA 10 held up the phone with her hand and passed it in front of their faces. There were several others at the table, she thought four or five other CNAs. She was so shocked and floored she just did not know what to do. CNA 8 was educated about reporting immediately. If it were to happen in the future, she would report to the nurse in charge, the DON, or the Administrator. Before she did any of that, she would make sure the resident was okay. During an interview with QMA 6 on 7/31/25 at 1:01 p.m., she indicated CNA 10 approached her about Resident C and proceeded to show a picture of the resident. CNA 10 told QMA 6 more than once she would delete the pictures from the phone. QMA 6 did not assess the resident at that point because she was aware the marks were from a bingo dauber, and she was not concerned about the resident's safety. Since the incident, staff had been educated and, in the future, if something like that were to happen again, she would immediately report to the administrator and if she could not reach the administrator she would contact the DON. During an interview with RN 9 on 7/31/25 at 12:32 p.m., she indicated it was nighttime and she heard one of the aides had a picture on her phone. Another aide approached her and told her about the picture. RN 9 asked CNA 10 to see the pictures, but CNA 10 told her there was nothing there. CNA 10 showed her deleted folder file. There was nothing there and nothing on the camera roll either. RN 9 never actually saw the pictures. The only reason she knew about it was one of the other CNAs said something about it. RN 9 told CNA 10 she could not have things like that on her phone and she could not take pictures of the residents. CNA 10 insisted that she had not saved the picture. CNA 10 did admit she took the picture, and told RN 9 she showed it to some of the other staff, then deleted it. RN 9 did not report it because she had other things happening that night and since she had not seen the picture herself, she did not think she could report it. Since being re-educated, she understood she should have reported it and felt very bad she did not. During an interview with CNA 5 on 7/31/25 at 1:09 p.m., she indicated CNA 10 showed her the picture and told her what happened. CNA 5 was not sure why CNA 10 took the picture. CNA 5 reported it after she saw the picture. She thought CNA 10's reason for taking the picture was to show the resident had marked herself with a bingo dauber while touching her vaginal area with the dauber. CNA 5 thought CNA 10 found it funny because she showed no concerns about Resident C. CNA 5 reported to the DON. During an interview with the DON 7/31/25 at 2:15 p.m., she indicated staff were re-educated on abuse. Everybody should be reporting if they suspected abuse. During an interview with the Administrator on 7/31/25 at 2:22 p.m. she indicated the incident was reported to her on</p>		