STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Persimmon Ridge Rehabilitation Centre	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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45122 Based on observation, record review, and interview, the facility failed to ensure non-pharmacological interventions were implemented prior to the PRN (as needed) administration of psychotropic medications for 2 of 6 residents reviewed for unnecessary medications. (Resident 39 and Resident 59) Findings include: 1. During an observation, on 8/14/24 at 10:16 a.m., Resident 39 sat quietly in a tilt-in-space positioning wheelchair in while watching a group activity. During an observation, on 8/15/24 at 8:57 a.m., the resident lay quietly in bed with her eyes closed in her darkened room. During an observation, on 8/16/24 at 8:32 a.m., the resident sat quietly in a tilt-in-space positioning wheelchair in the dining room at a table. Resident 39's clinical record was reviewed on 8/14/24 at 12:01 p.m. Diagnoses included Alzheimer's disease with early onset, psychotic disorder with hallucinations due to known physiological condition, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, recurrent, mild, generalized anxiety disorder, borderline personality disorder, and dementia. Physician's orders included buspirone (antianxiety) 10 mg three times a day (started 3/21/24), donepezil (for Alzheimer's) 10 mg daily (started 12/21/23), haloperidol lactate (antipsychotic) 2 mg/ml concentrate 5 mg twice a day (started 5/24/24), lorazepam (antianxiety) 0.5 mg three times a day PRN for generalized anxiety disorder (started 4/2/24 and discontinued 4/15/24), memantine (for Alzheimer's) 14 mg extended release daily (started 12/22/23) , and sertraline (antidepressant) 200 mg daily (started 4/19/24). A quarterly Minimum Data Set (MDS) assessment completed on 5/24/24 indicated the resident had no recall of current season, location of room, staff names and faces, or that she was in a nursing home. She had moderately impaired decision-making and made poor decisions. She exhibited physical behavioral symptoms both directed toward others and not directed toward others for one to three days during the assessment period. (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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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, initiated on 12/21/23 and last revised on 7/3/24, indicated the resident had a diagnosis of anxiety. The goals included the following: episodes of increased anxiety will be successfully addressed, and resident calmed as evident by documented efficacy of interventions listed in the Behavior Memo(s). Interventions will be effective as evidenced by fewer episodes of anxiety as evident by review of documented Behavior Memo(s) denoting number of episodes of anxiety exhibited. The interventions included the following: ensure calm environment, ensure all basic needs have been met, encourage activities of preference such as watching television, encourage resident to express thoughts and feelings, provide reassurance and comfort as needed, provide relaxation techniques as needed, such as visualization, relaxing music, and massage, and administer medication as ordered as needed. The medication administration record (MAR) for 4/5/24 through 4/15/24 indicated the resident had received the PRN lorazepam 0.5 mg on the following days 4/5/24 (twice), 4/6/24, 4/7/24, 4/8/24, 4/9/24 (twice), 4/11/24 (twice), 4/12/24, 4/13/24 (twice), 4/14/24 (twice), and 4/15/24 at 6:54 a.m. The MAR lacked documentation of non-pharmacological interventions attempted prior to the administration of the lorazepam. The Mood and Behavior Communication Memos, for the time span between 1/1/24 and 8/16/24, received from the DON on 8/16/24 at 10:24 a.m., were reviewed. The memos included the description of the resident's behavior, interventions attempted, and the outcome of the interventions used. No memos were completed for 4/9/24, 4/11/24, 4/12/24, 4/13/24, and 4/15/24 when Resident 39 received lorazepam. A nurses note, dated 3/28/24 at 9:25 a.m., indicated the mental health provider had been updated on an increase in the resident's yelling and behaviors. A new order was received (to increase sertraline 100 mg by 25 mg daily until dose reached 200 mg). A nurses note, dated 4/15/24 at 12:20 p.m., indicated the resident was sent to the hospital for increase in agitation and constant yelling and screaming. The nurses notes lacked the resident's behaviors and interventions provided for 4/9/24, 4/11/24, 4/12/24, 4/13/24, and 4/15/24 prior to administration of the PRN lorazepam. During an interview, on 8/16/24 at 4:21 p.m., RN 4 indicated prior to the administration of a PRN psychotropic medication, non-pharmacological interventions were to be provided such as redirecting the resident or offering a snack. She thought the interventions were to be documented on the MAR. During an interview, on 8/16/24 at 4:23 p.m. RN 5 indicated prior to the administration of a PRN psychotropic medication, reasons why giving the medication must be listed, try to redirect the behavior, and do the least invasive things before administering a medication. If the behavior is really bad, then a behavior report should be filled out and the interventions are put on the bottom. The interventions can be documented on the MAR and the nurses notes. During an interview, on 8/16/24 at 5:10 p.m., the DON indicated she was unable to locate documentation of interventions being provided prior to the administration of the lorazepam for Resident 39. 2. During an observation, on 8/12/24 at 10:52 a.m., Resident 59 laid on her bed with her eyes closed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 8/14/24 at 8:52 a.m., the resident laid on her bed watching television. During an observation, on 8/16/24 at 10:00 a.m., the resident laid on her bed and talked on the phone. Resident 59's clinical record was reviewed on 8/14/24 at 2:01 p.m. Diagnoses included depression, generalized anxiety disorder, emphysema, and chronic obstructive pulmonary disease. Physician's orders included lorazepam (antianxiety) 0.25 mg PRN three times a day for generalized anxiety disorder (started 6/19/24 and discontinued 8/8/24) and sertraline (antidepressant) 150 mg daily (started 8/8/24). A quarterly Minimum Data Set (MDS) assessment completed 7/23/24 indicated the resident was cognitively intact. No behaviors were identified. A current care plan (initiated 6/19/24 and last revised 8/5/24) indicated the resident required the use of an antianxiety medication. The goal was the resident would have no signs or symptoms of adverse reaction associated with the use of lorazepam through the next review. The interventions included the following: administer the medication as ordered, monitor for adverse effect, and observe for changes in mood or behavior. The medication administration record (MAR) for 7/21/24 through 7/31/24 indicated the resident had received the PRN lorazepam on the following days: 7/21/24 (twice), 7/22/24 (twice), 7/23/24, 7/24/24 (twice), 7/25/34, 7/26/24, 7/27/24, 7/28/24 (twice), 7/29/24 (twice), 7/30/24, and 7/31/24 (twice). The MAR lacked documentation of interventions given prior to the administration of the lorazepam. The Mood and Behavior Communication Memos, for the time span between 6/19/24 and 8/16/24, received from the DON on 8/16/24 at 2:29 p.m., were reviewed. The memos included the description of the resident's behavior, interventions attempted, and the outcome of the interventions used. No memos were completed for 7/21/24 through 7/29/24 and 7/31/24. A behavior memo concerning the resident's refusal of taking a shower because she was tired was completed on 7/30/24. The nurses notes lacked the resident's behaviors and interventions provided prior to the administration of the PRN lorazepam from 7/21/24 through 7/31/24. During an interview, on 8/16/24 at 2:15 p.m., QMA 2 indicated prior to the administration of a PRN psychotropic medication, non-medication type interventions should be attempted. The nurse would also have to give permission to give the PRN medication prior to a QMA administering the medication. During an interview, on 8/16/24 at 2:17 p.m. the Unit Manager indicated prior to giving a PRN psychotropic medication, a non-pharmacological intervention, should be attempted and documented. During an interview, on 8/16/24 at 4:34 p.m., the DON indicated prior to the administration of lorazepam she expected non-pharmacological interventions to be implemented such as relaxation then reevaluate before giving the medication. During an interview, on 8/16/24 at 5:10 p.m., the DON indicated she was unable to locate documentation of interventions being provided prior to the administration of the lorazepam for Resident 59. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy, revised 9/2017, provided by the DON on 8/16/24 at 5:34 p.m., titled PRN Medications, indicated PURPOSE: To ensure non-pharmacological interventions are attempted, as appropriate, prior to PRN medication administration .Upon resident request or nurse observation indicating potential need for PRN psychoactive medication, the nurse shall be responsible to intervene, as appropriate, and list/code all non-pharmacological approaches attempted to resolve the resident's symptom(s)

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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. 45122 Based on observation, record review, and interview, the facility failed to label over-the-counter medications with resident name and physician name and failed to dispose of expired medications for 1 of 6 medication carts observed. (Medication cart on 300 Hall) Findings include: During a medication storage observation of the 300 Hall medication cart for rooms 310 -317, on 8/16/24 at 2:07 p.m., accompanied by QMA 2, the following medications were observed and lacked a resident name and physician name: one container of melatonin 10 mg strength with initials written on the lid and one container of doxylamine succinate with initials written on the lid. An opened container of antifriction, body powder lacked a resident name, physician name, directions, and an expiration date. A container of psyllium fiber supplement with a last name on the lid lacked a physician name and had expired 8/2020. During an interview at the same time of the observation, QMA 2 indicated over-the-counter medications should have the resident's name, the prescriber's name, and the date opened on them. The expired medication should have been disposed of. During an interview, on 8/16/24 at 2:17 p.m., the Unit Manager indicated over-the-counter medications should be labeled with the resident's name, the prescriber's name, the date opened, and the directions. The container of psyllium fiber supplement belonged to a resident who had admitted from home, and she thought the family had provided the medication. During an interview, on 8/16/24 at 2:26 p.m., the DON indicated expired medications should be disposed of and medications should have resident names and prescriber names on them. A facility policy, dated 4/2021, provided by the DON on 8/16/24 at 2:35 p.m., titled Drug Labels, indicated the following: .Drugs will be labeled in compliance with federal and state laws as well as standards of pharmacy practice A facility policy, dated 4/2021, provided by the DON on 8/16/24 at 2:35 p.m., titled Storing Drugs, indicated the following: .Any outdated, contaminated, or deteriorated drugs, or those that have containers that are cracked, soiled, or without closures must be removed from stock and destroyed according to policy 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(o)