STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155791	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blair Ridge Health Campus	269 Meadowview Dr Peru, IN 46970

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store and prepare food in a sanitary manor related to food not sealed or dated and expired food items and food service equipement and dishes not clean in 1 of 1 kitchen observed. This deficient practice had the potential to affect 47 of 49 residents who consumed food from the kitchen.Findings include: 1. During the initial tour of the kitchen, on 7/22/2025 at 9:41 A.M., with the Dietary Manager, the following was observed in the walk-in cooler:- a brown paper bag with squash and other vegetables with a use by date of 7/20/2025.- 2 bags of vegetables cut in chunks with no date received or use by date. During an interview, on 7/22/2025 at 9:47 A.M., the Dietary Manager indicated the out dated vegetables should have been removed and the chunk cut vegetables should have been dated. 2. During a follow-up visit to the kitchen on 7/25/2025 at 9:30 A.M., the following was observed:- the plate warmer used to store clean dinner plates had yellow/rust colored grease along the bottom of the warmer- a small refrigerator used for drinks had a large build up of ice along the back wall extending down to the bottom surface of the refrigerator.- the sandwich cooler had dried specs of food substances along the bottom surface and along the rubber seals.- the char broiler had a large build up of black grease and dried food debris- two medium and two small steam table pans and two food serving scoops put away as clean and dry were visibly wet During an interview, on 7/25/2025 at 9:45 A M., the Dietary Manager indicated the plate warmer was not clean, the refrigerator should have been defrosted, the cooler was not clean, the char broiler should have been cleaned and the cooking utensils were not clean and should not have been put away wet. On 7/28/2025 at 2:15 P.M., the Administrator provided the policy titled, Food Labeling and Dating, dated 3/18/2019, an indicated the policy was the one currently use by the facility. The policy indicated . Any food product removed from its original container, had a broken seal, has been processed in any way must have a label that contains the following: 1. Item Name. 2. Date and Time the food was labeled. 3. Use by date. 4. Initials of the person labeling the item. 5. Securely cover the food item On 7/28/2025 at 2:15 P.M., the Administrator provided the policy titled, Storage Procedures, dated 5/31/2016, and indicated the policy was the one currently used by the facility. The policy indicated . 6. Open packagers are labeled, dated, and stored in closed containers . 3. Refrigeration equipment is routinely cleaned and defrosted and free from garbage and other waste . On 7/28/2025 at 2:15 P.M., the Administrator provided the policy titled, Retail Food Establishment Sanitation Requirements, and indicated the policy was the one currently used by the facility. The policy indicated .Food debris on equipment and utensils shall be: (1) scrapped over a waste disposal unit or garbage receptacle; or (2) removed in a ware washing machine with a prewash cycle. (b) If necessary for effective cleaning, utensils and equipment shall be pre-flushed, or presoaked, or scrubbed with abrasives . Equipment and utensils; air drying required. (a) After cleaning and sanitizing, equipment and utensils (1) shall be air-dried or used after adequate draining as specified . before contact with food 3.1-21(i)(3)

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to provide a transfer/discharge form for 1 of 2 residents reviewed for hospitalizations. (Resident C)Finding includes:A record review for Resident C was completed on 7/25/2025 at 8:55 A.M. Diagnoses included, but were not limited to: dementia, mood disorder, anxiety disorder, psychotic disorder with hallucinations and sleep disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 6/20/2025, indicated Resident C had severe cognitive impairment, had delusions and verbal behaviors for one to three days of the 14-day look back period. A Nursing Progress Note, on 7/18/2025 at 10:37 A.M., indicated Resident C was admitted to a psychiatric hospital due to increased behaviors of hallucinations and delusions. A Transfer/Discharge Form could not be located in the medical record. During an interview, on 7/29/2025 at 1:01 P.M., the Executive Director indicated a transfer/discharge form had not been located. She indicated a transfer/discharge form should have been provided to the resident or the resident's representative when the resident was transferred to the mental health hospital. A current policy was provided on 7/29/2025 at 1:16 P.M., by the Executive Director. The policy titled, Guidelines for Transfer and Discharge, indicated, .According to federal regulations, the facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility .Procedures should include: a. Notify the resident in writing, and if known, a family member or legal representative, 30 days in advance, of the transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged , and the reason for the transfer or discharge, according to the criteria for transfer or discharge. Exceptions to the a 30-day requirement are if/when a resident is endangering the health or safety of themselves or others, when a resident's health has improved to all an immediate transfer, or discharge, when a resident's urgent medical needs require immediate transfer, and when a has not resided in the facility for 30 days. b. Record the reasons for, the effective date of transfer or discharge, and the location to which the resident is being transferred or discharged in the medical record and on a discharge form or a letter. Give a copy of the discharge notice to the resident and his/her family legal representative 3.1-12(a)(8)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review and interview, the facility failed to ensure appropriate interventions were implemented to address hyponatremia for 1 of 1 residents reviewed for a change in condition. (Resident 3)Finding includes:During an observation, on 7/22/2025 at 10:22 A.M., Resident 3 had four rows lined up of cartons of Jevity 237 milliliters (supplemental nutrition) and 3 plastic cups containing various amounts of water on the over-the-bed table at the end of his bed. During an observation, on 7/23/2025 at 8:57 A.M., Resident 3 was sitting in his room next to the window and his bed. He had four rows lined up of cartons of Jevity 237 milliliters and 3 plastic cups containing various amounts of water on the over-the-bed table at the end of his bed. A record review for Resident 3 was completed on 7/25/2025 at 1:06 P.M. Diagnoses included, but were not limited to: hemiplegia, protein-calorie nutrition, hyponatremia and dementia. An Annual Minimum Data Set (MDS) assessment, dated 6/27/2025, indicated Resident 3 had severe cognitive impairment and received tube feedings and fluids with 501 milliliters or greater of fluids provided via a gastronomy tube. A Nurse Practitioner Note, dated 6/25/2025 at 10:59 P.M. and recorded late on 6/29/2025 at 11:04 P.M., indicated Resident 3 had been seen related to laboratory results from 6/24/2025 that showed hyponatremia (low sodium level) with a sodium value of 131 mmol/L (millimoles per liter). The normal range per the laboratory test results was 136-145 mmol/L. The note indicated Resident 3 had been spending most of his time outdoors in the hot weather and received feedings and fluids via a PEG tube (percutaneous endoscopic gastronomy tube). Resident 3 had remained asymptomatic despite the hyponatremia. Resident 3 had a BUN (blood urea nitrogen) level of 22 mg/dL (milligrams per deciliter) and a creatinine level of 0.8 mg/dL. (The values of the BUN and creatinine were within normal range and could have indicated dehydration if elevated). The plan for the hyponatremia included to add an additional 90 milliliters of water at each bolus feeding (5 times a day) for 30 days due to Resident 3 spending an increased amount of time outdoors. However, the assessment and lab results did not support a dehydration diagnosis.A General Physician's Order was processed, on 6/25/2025 at 1:59 P.M., for an additional 90 milliliters of water at each bolus feeding, five times per day related to hyponatremia. A Nutritional Assessment, dated 7/16/2025, indicated Resident 3 required 2,345 milliliters of fluid daily. A Nutritional Progress Note, on 7/16/2025 at 12:56 P.M., indicated the Registered Dietician estimated Resident 3's fluid intake as the following:-Jevity 1.5 bolus five times daily equaling 900 milliliters of free fluid in the formula.-Water flush orders before and after bolus feeding of 60 milliliters equaling 600 milliliters.-Water flush orders of 90 milliliters, twice daily, equaling 180 milliliters.-Water flushes with medications of 180 milliliters equaling 960 milliliters.-An extra 90 milliliters at each bolus feeding for 30 days related to spending time outdoors equaling an additional 450 milliliters.-The total fluid via the g-tube (gastronomy tube) was 2,595 milliliters per day for 30 daysA Nursing Progress Note, on 7/23/2025 at 9:30 A.M., indicated the hyponatremia had been treated with additional G-tube fluids. A Care Plan, initiated on 4/6/2018 and updated on 7/11/2025, indicated Resident 3 was at risk for dehydration/fluid imbalance related to g-tube, dysphagia and NPO (nothing by mouth) status. The goal was for Resident 3 to remain adequately hydrated and not display signs or symptoms of dehydration. The interventions included, but were not limited to: observe for clinical signs and symptoms of dehydration including dry mouth, thirst, restlessness, irritability, tenting skin turgor, dry mucous membranes, sunken eyes, dry/warm skin decreased urinary output and etc. (et cetera).A professional reference from the Mayo Clinic, at https://www.mayoclinic.org ? syc-20373711, indicated, .In hyponatremia, one or more factors cause the sodium in the body to be diluted. These factors can range from an underlying medical condition to drinking too much water. When this happens, the body's water levels rise, and cells begin to swell. This swelling can cause many health problems, from mild to life-threatening. Hyponatremia treatment is aimed at resolving the underlying condition. Depending on the cause of hyponatremia, you may simply need to cut back on how much you drink. In other cases of hyponatremia, you may need intravenous electrolyte solutions (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and medications During an interview, on 7/29/2025 at 9:38 A.M., Resident 3's Nurse Practitioner indicated the treatment for hyponatremia would depend on the resident's situation including dehydration, chronic kidney disease and hypovolemia or hypervolemia and the medications the resident had received. She indicated she used intravenous fluids, stopped medication that could have caused the hyponatremia and assessed for symptoms of congestive heart failure. She indicated Resident 3 was in the garden all the time during hot weather and at the time of his assessment, looked diaphoretic, so she had increased the fluids a little bit. She indicated the professional reference of decreasing the fluids was correct and the treatment was not to give more fluids as extra fluids would further deplete sodium levels. She indicated a follow-up laboratory test for sodium should have been completed to follow up on the hyponatremia after the ordered treatment of extra fluids.A policy was requested for abnormal labs and electrolyte imbalances. On 7/29/2025 at 11:28 A.M., the Director of Nursing indicated the requested policies were not available. 3.1-37(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure pre and post dialysis treatment assessments were completed for 1 of 1 residents reviewed for dialysis management (Resident 5). Finding includes:A record review was completed for Resident 5 on 7/24/2025 at 1:55 P.M. Diagnoses included, but were not limited to: hypertensive heart and chronic kidney disease, stage 5 chronic kidney disease and end stage renal disease. A Physician's Order, dated 6/17/2025 indicated Resident 5 was to receive dialysis treatments every Tuesday, Thursday and Saturday and staff were to complete the Dialysis Center Communication Observation form and send the form with the resident. A current Care Plan, dated 6/19/2025 indicated Resident 5 had renal failure resulting in the need for dialysis. Interventions included, but were not limited to: coordinate care with dialysis center and resident was to receive dialysis on Tuesday, Thursday and Saturday at 5:20 A.M. A review of Resident 5's Dialysis Center Communication Observations indicated the pre and post dialysis assessment were not completed as they lacked vital signs and weights on the following dates:6/21/20256/24/20257/10/20257/12/20257/15/20257/17/2025During an interview, on 7/28/2025 at 10:33 A.M., the DON indicated the Dialysis Communication Center Observations forms should have been completed prior to the resident leaving for dialysis and upon their return. She indicated the forms should have included the residents vital signs and weights.On 7/28/2025 at 11:26 A.M., the DON provided the facility policy titled, Guidelines for Dialysis, undated and indicated it was the policy currently used by the facility. The policy indicated, .Purpose: To provide communication to Dialysis Providers and monitoring of residents receiving dialysis. 4. A report (may be written or verbal) shall be requested from the Dialysis Provider that will alert the campus regarding: b. vital signs 3.1-37(a)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, record review and staff interviews, the facility failed to ensure 1 of 2 nurses observed during medication administration was competent to provide safe medication administration. (LPN 3)Findings include: During an observation, on 7/22/2025 at 11:18 A.M., Resident 13 was observed laying on her bed fully dressed with her eyes closed. There was a partially eaten breakfast tray on her over bed table. Between her water container and a coffee cup, there was a clear plastic medicine cup containing five pills, a dark green oblong capsule, a pale green and yellow oblong capsule, and 3 white round tablets. The resident awakened indicated that she did not know what medications were in the cup or why the cup was sitting on her table. During an interview, on 7/22/2025 at 11:28 A.M., Licensed Practical Nurse (LPN) 3 was notified of the cup of medications discovered on Resident 13's breakfast tray. She indicated there should have been 6 pills in the medicine cup and that it appeared the iron tablet was missing. LPN 3 then removed the remaining 5 pills from the resident's room. LPN 3 indicated that she had prepared Resident 13's medications during the 8:00 A.M. medication pass and had left them on the resident's bedside table for the resident to take when she was ready. LPN 3 indicated she should have witnessed Resident 13 consume the medications and the medications should not have been left on the bedside table. LPN 13 indicated she had signed the medications as received on the Medication Administration Record. The record for Resident 13 was reviewed on 7/29/2025 at 12:00 P.M. The record indiated Resident 13 did not have a physician's order to self-administer her own medication. In addition, Resident 13 was moderately cognitively impaired and had a diagnosis of dementia.During an interview, on 7/29/2025 at 11:47 A.M., the interim DON indicated a few residents were able to self-administer medications but they must have a doctor's order and have completed the self-administration evaluation to ensure the resident's safety and understanding (of medications). The interim DON indicated the medications that were found in Resident 13's room should have been destroyed and hte MAR corrected to reflect the occurrence. Review of Resident 13's MAR indicated the documentation for the 7/22/2025 AM medications, dispensed between 6:00 A.M. and 10:00 A.M., had not been corrected A policy was provided, on 7/29/2025 at 11:42 A.M., by the interim DON. The policy titled, IIA2; Medication administration general guidelines. indicated , .when medications are administered by mobile cart and taken to the resident's location, medications are to be administered at the time they are prepared , 2.the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. If a dose of regularly scheduled medication is given at a time other than a scheduled time, it is documented on MAR or in the EHR. An explanatory note is also entered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review and staff interviews, the facility failed to ensure medications were administered according to physician's orders and professional standards for 5 of 32 opportunities resulting in a medication administration error rate of 15.63% (Resident 13)Findings include: During an observation, on 7/22/2025 at 11:18 A.M., Resident 13 was observed laying on her bed fully dressed with her eyes closed. On her bedside table, on her breakfast tray between her water container and her coffee cup was a clear plastic medicine cup containing five pills, a dark green oblong capsule, a pale green and yellow oblong capsule, and 3 white round tablets. During an interview, on 7/22/2025 at 11:28 A.M., Licensed Practical Nurse (LPN) 3 indicated there should have been six pills in the medication cup. She indicated she had prepared the medications for Resident 13 earlier in the morning, around 8:00 A.M. and had left them on the bedside table for the resident to take when she was ready. LPN 3 indicated she should have witnessed the resident take the medications and should not have left medications on the bedside table. During a record review, on 7/22/2025 at 2:00 P.M., Resident 13's Medication Administration Record (MAR) indicated that LPN 3 had documented that the following medications had been administered between 6:00 AM and 10:00 AM: Aggrenox ER (platelet inhibitor used to prevent strokes) 25 -200 mg 1 capsule, carvedilol (used to treat high blood pressure) 25 mg 1 tablet, FeroSul (iron supplement) 325 mg 1 tablet, Fluoxetine (anitdepressant) 20 mg and 10 mg tablets (2 tablets total), furosemide (diuretic) 40 mg 1 tablet, Namenda XR (used to treat dementia) 28 mg 1 tablet, and Vitamin D3 50 mcg 1 tablet for a total of eight individual pills. During an interview and observation, on 7/29/2025 at 10:07 A.M., LPN 4 provided Resident 13's medication pouches prepared by the pharmacy for review. The A.M. medication pouches were divided between 2 pouches with 5 pills in one pouch and 2 pills in the second pouch. The pouches included the following medications:Carvedilol 25 mg (large round tablet) for hypertensionFerrous Sulfate 325 (large round dark green tablet) for anemiaFluoxetine 20 mg capsule (green/yellow capsule) for depressionFluoxetine 10 mg capsule (all green capsule) for depressionVitamin D3 2000 mg (round white tablet) for low Vitamin D levelsNamenda XR 28 mg (dark green pill) for dementiaFurosemide 40 mg (round white tablet) for blood pressureIn addition, there was a separate pill bottle containing Aggrenox ER (large maroon and yellow capsule) for blood thinning).During an interview, on 7/29/2025 at 11:47 A.M., the interim DON indicated the medications that had been found in Resident 13's room should have been destroyed and the MAR corrected to reflect the errors of omissions However, review of Resident 13's MAR for the 7/22/2025 AM medications dispensed between 6:00 A.M. and 10:00 A.M. indicated they had all been administered, even though they had not been administered. In addition, there was no documentation the physician had been made aware of the medication omission errors.A policy was provided, on 7/29/2025 at 11:42 A.M., by the interim DON. The policy titled, IIA2; Medication administration general guidelines. indicated , .when medications are administered by mobile cart and taken to the resident's location, medications are to be administered at the time they are prepared , 2.the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. If a dose of regularly scheduled medication is given at a time other than a scheduled time, it is documented on MAR or in the EHR. An explanatory note is also entered.3.1-48(c)(1)