STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 3, 4, 5, 8, and 9th, 2023. Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 90 SNF: 7 Total: 97 Census Payor Type: Medicare: 7 Medicaid: 82 Other: 8 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 16, 2023	F 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for annual survey completed on 5/9/2023. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director Rosebud Village	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide oral care for a dependent resident and nail care for a dependent resident for 2 of 5 residents reviewed for	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari Alcorn		05/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Activities Of Daily Living (ADL) (Resident 49 and Resident 27). Findings include: 1.) During an observation on 5/03/23 at 12:24 p.m., Resident 49's teeth were dirty and had a thick film over her teeth, with mouth odor when speaking. During an observation on 5/4/23 at 12:00 p.m., Resident 49 was sitting in front of the nursing station, the resident smiles and has a thick film with white substance between her teeth. Review of the record of Resident 49 on 5/8/23 at 11:40 p.m., indicated the resident's diagnoses, included but were not limited to, Alzheimer's disease, dementia, depression and hypertension. The plan of care for Resident 49, dated 3/16/23, indicated the resident required assistance with ADL's. The interventions included, but were not limited to, assist with oral care twice a day. The Admission Minimum Data (MDS) assessment for Resident 49, dated 3/21/23, indicated the resident was severely cognitively impaired. The resident required extensive assistance of one personal hygiene to include brushing teeth. During an interview with the Director Of Nursing (DON) on 5/8/23 at 3:00 p.m., CNA's are responsible for oral care. The customer care representatives are suppose to checking routinely also. The nursing policy provided by the Administrator on 5/9/23 at 10:55 a.m., indicated the purpose was to ensure residents care was provided in a safe and sanitary manner to prevent the spread of		**practice.** · Resident 49 was provided oral care and will be provided oral care per preference and policy. · Resident 27 was provided with nail care and will be provided with nail care per preference and policy. · Care plans for residents 49 and 27 have been updated to reflect preferences. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** · All residents that are dependent for care have the potential to be affected by the alleged deficient practice. · An audit will be completed to ensure that all dependent residents receive ADL care per plan of care. · All nursing staff will be in-serviced on providing ADL care for dependent residents by the DNS or designee by 6/15/23. **What measures will be put into place or what systemic**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	infection. The general resident care included provide or assist with oral care at least two times a day or as needed. 2.) During an observation on 5/03/23 at 2:04 p.m., Resident 27 was laying in bed, the resident's fingernails were long. During an observation on 5/04/23 at 10:05 a.m., Resident 27's left and right hand contracture with no splint in place or device in place. Resident 27's fingernails were long. During an observation on 5/5/23 at 12:06 p.m., Resident 27 was sitting in the dining room, the resident's fingernails were long. Review of record of Resident 27 on 5/9/23 at 12:50 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, Parkinson's disease, quadriplegia, hypertensive heart disease, neurocognitive disorder with Lewy bodies, anxiety, age related physical debility, right and left hand contracture, reduced mobility, seizures, muscle weakness and traumatic brain injury. The Significant Change MDS assessment for Resident 27, dated 4/18/23, indicated the resident was severely impaired for daily decision making. The resident was totally dependent for personal hygiene of one person. The resident had functional limitation in range of motion in range of motion on one side of the upper extremity. During an interview with Director Of Nursing (DON) on 5/5/23 at 1:10 p.m., CNA's and hospice staff were responsible to ensure Resident 27's fingernails were kept trimmed. During an observation and interview with the		**changes will be made to ensure that the deficient practice does not recur.** · DNS or designee will complete daily rounds to ensure that all dependent residents receive ADL care per plan of care and preference. · All nursing staff will be in-serviced on providing ADL care for dependent residents by the DNS or designee by 6/15/23 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.** · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Resident Care Rounds QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DON on 5/5/23 at 1:17 p.m., Resident 27's left palm had slight redness with no open areas and no open areas on right palm. The resident had long fingernails on both hands. Resident 27 indicated it was ok for staff to cut his fingernails. The DON indicated she would have staff cut his fingernails. 3.1-38(a)(3)(C) 3.1-38(a)(3)(E)		**By what date the systemic changes will be completed.** · **Completion date: 6/15/22**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to assess and document abrasions on a cognitively impaired resident. This affected 1 of 2 residents reviewed for non-pressure related skin conditions. (Resident 73) Findings include: On 5/03/23, at 12:30 p.m., Resident 73 was observed to have three abrasions on the back of his left hand. A family member, sitting with the resident, indicated she didn't know how it happened. On 5/05/23, at 9:46 a.m., Resident 73 sat in the activity/dining area, fully dressed, in a wheelchair	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · · A skin assessment was completed on resident 73 to include abrasions on back of left hand with family and physician notification and documentation. · · Wound management followed the abrasions until they were healed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with foot rests. He was confused and spoke few words. The scratched areas on his left hand were fading. Resident 73's record was reviewed on 5/05/23 at 10:05 a.m., and indicated diagnoses that included, but were not limited to, Alzheimer's disease, dementia, generalized muscle weakness, need for assistance with personal care, and history of transient ischemic attacks. An Admission Minimum Data Set (MDS) assessment, dated 1/17/23, indicated Resident 73 was severely impaired in cognitive skills for daily decision making, had no behaviors, and no skin issues, and required extensive assistance of 1-2 staff for activities of daily living. A Quarterly MDS assessment, dated 4/11/23, indicated Resident 73 was severely impaired in cognitive skills for daily decision making, he had no behaviors, he had skin tears, required extensive assistance of 1-2 staff for activities of daily living, and has had 2 or more falls since admission. There was no documentation in the clinical record that addressed the scratched areas on the back of his left hand. On 5/8/23, at 2:08 p.m., the Director of Health Services indicated the scratches were not in their wound management to follow, and they added them in wound management to follow them. She said that, from the staff interviewed, it sounded like they occurred from the last fall. A Policy for "Skin Management Program" was provided by the Director of Nursing Services on 5/9/23 at 3:00 p.m. The policy included, but was		**action(s) will be taken;** · ·All residents have the potential to be affected by the alleged deficient practice. · ·All nursing staff to be in-serviced on the skin management program and reporting any skin alterations to licensed nurse for further assessment and documentation by the DNS or designee by 6/15/23. · ·DNS assessed residents for non-pressure related skin conditions and documented as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · ·All Nursing staff to be in-serviced on the skin management program and reporting any skin alterations to licensed nurse for further assessment and documentation by the DNS or designee by 6/15/23. · ·Charge nurse will observe for any skin alterations daily and document as needed. · ·Nurse managers will observe for any skin alterations daily and document as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not limited to, "6. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include, but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported...." 3.1-37(a)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** · On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Wound and Skin Management QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;** **Completion date: 6/15/22**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review the facility failed to assess and implement an intervention for a resident with bilateral hand contractures for 1 of 2 residents reviewed for limited range of motion (Resident 27). Finding include: During an observation on 5/03/23 at 2:04 p.m., Resident 27 was laying in bed his left and right hand contractures, the resident had no splint or device in his hands. During an observation on 5/04/23 at 10:05 a.m., Resident 27's left and right hand contractures with no splint in place or device in place. Resident 27's fingernails were long. During an observation on 5/5/23 at 12:06 p.m., Resident 27 was sitting in the dining room with right and left contractures with no splint or device in place. Resident 27's fingernails were long. Review of record of Resident 27 on 2/9/23 at 12:50 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, Parkinson's disease, quadriplegia, hypertensive heart disease,	F 0688	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · ·Resident 27 was ordered a device for hand contractures and plan of care was updated. ·**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · ·All residents with decreased ROM/Mobility have the potential to be affected by the alleged deficient practice. · ·An audit will be completed to ensure that all residents with decreased ROM/Mobility are free from contractures. **What measures will be put into**	06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	neurocognitive disorder with Lewy bodies, anxiety, age related physical debility, right and left hand contracture, reduced mobility, seizures, muscle weakness and traumatic brain injury. The plan of care for Resident 27, dated 9/22/2019, indicated the resident had impaired mobility related to spastic quadraparesis, contracture to the left and right hand. The intervention included, but were not limited to, washcloth or ADB pads to bilateral hand contractures (5/5/23). The Significant Change MDS assessment for Resident 27, dated 4/18/23, indicated the resident was severely impaired for daily decision making. The resident was totally dependent for personal hygiene of one person. The resident had functional limitation in range of motion in range of motion on one side of the upper extremity. During an interview with the Director Of Nursing on 5/5/23 at 1:10 p.m., indicated she was unsure why Resident 27 did not have a carrot, washcloth or splint in place for bilateral hand contractures. During an observation and interview with the DON on 5/5/23 at 1:17 p.m., Resident 27's left palm had slight redness with no open areas and no open areas on right palm. The resident with long fingernails on both hands were long. Resident 27 indicated it was ok for staff to cut his fingernails and it was ok to place a washcloth in his contracted hands. During an interview with the DON on 5/8/23 at 2:45 p.m., indicated the Interdisciplinary Team (IDT) was responsible to assess and implement an intervention with the quarterly care plan assessment for Resident 27's bilateral hand contractures. The DON indicated that Resident 27		**place or what systemic changes will be made to ensure that the deficient practice does not recur;** · ·All staff to be educated on wound care prevention and intervention policy including decreased ROM/mobility by DNS or designee by 6/15/23. · ·Charge nurse will observe for decreased ROM/mobility and implement interventions as needed. · ·Residents will be observed for decreased ROM/Mobility on quarterly scheduled assessments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** · On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Resident Care Rounds QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	use to propel himself in the wheelchair with his right hand and the resident has declined and no longer does this, the resident's right hand contracture was fairly new. The wound care prevention and intervention policy provided by the Administrator on 5/9/23 at 10:55 a.m., indicated the foundation of pressure injury management is prevention. The purpose of the recognition and assessment phases for residents who have not developed a pressure injury is to provide the framework for implementation of prevention strategy that reduces the risk of pressure injury occurrence. Implement wound care prevention measures for all residents who are risk based on root cause analysis. The resident at risk for developing pressure injury, included, but were not limited to, impaired or decreased mobility. Residents with contractures should be assessed routinely. 3.1-42(a)(2)		met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;** · **Completion date: 6/15/22**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to promote an environment to safeguard potentially hazardous chemicals by leaving a bottle of covid reagent solution on Resident 58's table for 1 of 1 residents reviewed for accidental	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hazards. (Resident 58) Findings include: The clinical record for Resident 58 was reviewed on 5/5/2023 at 11:43 a.m. The medical diagnoses included schizophrenia and cataracts. An Annual Minimum Data Set Assessment, dated 3/16/2023, indicated that Resident 58 was cognitively intact. An interview on 5/4/2023 at 11:48 a.m. indicated that a few months ago, a nurse put covid reagent solution into her eyes after a cataract surgery. She indicated the nurse came in, sat a medicated nose spray and what the resident believed was her eye drops in front of her then the nurse went around to give her roommate medicine. The nurse then came back and administered the solution to Resident 58's eyes, which the nurse then stated was "covid solution". A written statement from RN 1 indicated on 12/27/2022, that she went into Resident 58's room with her nasal spray and what the nurse believed were her eye drops. Prior to administering, the nurse realized that the bottle was covid reagent solution. She then sat the covid reagent solution and medicated nasal spray on the bedside table then told the resident not to touch anything. The nurse stepped out to the hallway to get the correct eye drops, leaving the medicated nasal spray and covid reagent solution at the bedside. When the nurse returned, Resident 58 stated she had given herself the nasal spray and what the resident believed were eye drops. The nurse notified the on-call provider to notify that Resident 58 has reported administering covid reagent in her eyes.		**practice;** · · A room review was completed for resident 58, with permission, to ensure room is free from accident hazards and devices. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · · All residents have the potential to be affected by the alleged deficient practice. · · All resident rooms have been reviewed for potential hazards. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · · All staff to be educated on potential hazards including proper storage of medications and biologicals by DNS or designee by 6/15/23. · · Charge nurse will observe for any potential hazards. · · Nurse managers will observe for any potential hazards daily during care rounds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A policy entitled "LTC Facility's Pharmacy Services and Procedure Manual", was provided by the Executive Director on 5/9/2023 at 11:45 a.m. The policy indicated, " ...Facility should ensure that medications and biologicals are stored in an orderly manner ..." An interview with the executive director on 5/9/2023 at 11:45 a.m. indicated that chemicals should not be left unattended by staff at the bedside. 3.1-45(a)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** · On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Resident Care Rounds QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;** · **Completion date: 6/15/22**	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview, observation, and record review, the facility failed to ensure that urinary catheter tubing remained off of the floor for Resident 32 while sitting in the wheelchair for 1 of 3 residents reviewed for urinary catheters. (Resident 32) Findings included:	F 0690	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • Resident 32 was reviewed for catheter placement on wheelchair and placement was adjusted to prevent from touching ground. How other residents having the	06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The medical record for Resident 32 was reviewed on 5/8/2023 at 1:22 p.m. The medical diagnosis included obstructive uropathy and weakness. A Significant Change of Condition Minimum Data Set Assessment, dated for 2/13/2023, indicated that Resident 32 was cognitively intact and needed extensive assistance of two staff members for toileting tasks. A urinary catheter care plan for Resident 32, dated 1/12/2023, indicated to not allow the tubing or drainage system to contact the floor. An observation on 5/3/2023 at 12:45 p.m. indicated that Resident 32 was sitting in her wheelchair in her room with her urinary catheter tubing contacting the ground. An observation on 5/3/2023 at 2:30 p.m. indicated that Resident 32's spouse was propelling her in the wheelchair in the common hallway with her urinary catheter tubing touching the ground. A skills competency, entitled "Urinary Catheter Insertion (Indwelling)", was provided by the Executive Director on 5/9/2023 at 11:00 a.m. The competency indicated, " ...Place foley catheter bag below the level of the bladder without allowing bag or tubing to touch the floor ..." 3.1-37(a)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents with catheters who utilize wheelchairs have the potential to be affected by the alleged deficient practice. • Residents with catheters who utilize wheelchairs have been reviewed to ensure that proper placement of catheter bag prevents touching the floor. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • All staff to be educated on proper placement of urinary catheter bag on wheelchairs to ensure placement prevents touching of the floor by DNS or designee by 6/15/23. • Charge nurses will observe for proper catheter placement daily. • Nurse managers will observe for proper catheter placement daily on care rounds. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Director. • Resident Care Rounds QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. • If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 6/15/22	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview, observation, and record review, the facility failed to ensure a physician order for parenteral fluids had the correct route and included a rate and failed to document total volume of fluids infused for Resident 6 for 1 of 1 reviewed for parenteral fluids. (Resident 6) Findings included: The clinical record for Resident 6 was reviewed on 5/5/2023 at 11:02 a.m. The medical diagnoses included chronic kidney disease and endometrial cancer. A Significant Change of Condition Minimum Data	F 0694	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • Resident 6 received subcutaneous hydration as ordered and documentation has been adjusted in medical record to include route, rate and total volume of fluids infused. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Set Assessment, dated 2/14/2023, indicated Resident 6 had a mild cognitive impairment. A provider progress note, dated 5/2/2023, indicated that Resident 6 was having gastrointestinal upset related to her radiation treatment and that a fluid bolus of normal saline would be administered at 50 milliliters an hour (ml/hr) for a total of 500 ml (an anticipated run time of 10 hours). A nursing progress note, dated 5/2/2023 at 2:25 p.m., indicated that Resident 6 had a subcutaneous button placed. A subcutaneous button is an indwelling subcutaneous catheter used for administration of medication or fluids into the fatty tissue under the skin. A physician order for Resident 6, dated 5/2/2023, stated to have normal saline 500 ml intravenously (to be administered through a vein). No rate was indicated on this order. The medication administration record for Resident 6 indicated that the order for normal saline was signed off for 2:00 p.m. on 5/2/2023. A nursing progress note, dated 5/2/2023 at 8:51 p.m., indicated Resident 6 was receiving fluids subcutaneous button. The medication administration record for Resident 6 indicated on 5/3/2023 at 5:29 a.m. that fluids were still infusing (between 14 to 15 hours after initiation of fluids). A nursing progress note, dated 5/3/2023 at 5:41 a.m., indicated Resident 6 was receiving fluids intravenously to the right lower abdomen at 50 ml/hr.		• All residents who are prescribed parenteral/IV fluids have the potential to be affected by the alleged deficient practice. • DNS/designee reviewed residents who received parenteral/IV fluids to ensure a physician order had the correct route and included a rate. • DNS/designee reviewed resident who received parenteral/IV fluids to ensure documentation reflected the total volume of fluids infused. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. • Residents with order for parenteral/IV fluids will be reviewed by DNS or designee to ensure the physician order has the correct route and rate included. • Residents with orders for parenteral/IV fluids will be reviewed by DNS or designee to ensure that documentation is present for total volume of fluids infused. • All LPN's and RN's to be educated on subcutaneous IV fluids insertion for fluid administration by DNS or designee by 6/15/23. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview and observation on 5/3/2023 at 12:47 p.m., indicated Resident 6 laying in bed at this time with a 500 ml bag of normal saline being administered through a subcutaneous button attached to her abdomen. The bag of fluids level was between 100- and 200-ml. Resident 6 indicated she was getting fluids due to recent gastrointestinal upset related to her cancer treatment since yesterday evening and beginning to be able to keep down oral fluids. No total volume of parenteral fluids was documented on the medical record for Resident 6 on 5/2/2023 or 5/3/2023. A policy entitled, "Subcutaneous IV Insertion for Fluid Administration", was provided by the Executive Director on 5/9/2023 at 11:00 a.m. The policy indicated, " ...Verify the physician's order, route, IV solution, flow rate of administration ..." 3.1-47(a)(2)		• Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • Parenteral Therapy/PICC/IV Line QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. • If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 6/15/22	
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on interview and observation, the facility failed to follow dietary menus as written for 2 of 5 meals observed. Findings include: The lunch menu for 5/3/2023, indicated the meal would consist of cream of potato soup, saltine crackers, chicken salad fruit plate, a blueberry muffin, and butter. An observation and interview with Resident 95 on 5/3/2023 at 12:02 p.m., indicated that she was served cream of potato soup, grilled cheese, and canned pineapple. She indicated that her meal was missing her muffin and chicken salad. She stated that it is hit and miss with the kitchen, that sometimes they are good about making sure they give you what is on the menu and sometimes it is bad. An observation and interview with Resident 32 on 5/3/2023 at 1:14 p.m., indicated the lunch meal consisted of cream of potato soup, canned pineapple, and a grilled cheese sandwich. She stated that she did not get the chicken salad fruit plate nor muffin and that that the kitchen does not serve what is ordered.	F 0803	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • RD notified of menu substitutions for meals on 5/3/23 and 5/5/23. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents who have diet orders have the potential to be affected by the alleged deficient practice. • Culinary Department to be educated by ED/designee on menu adherence by 6/15/23. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • Culinary Department to be educated by ED/designee on menu adherence by 6/15/23. • Culinary Manager to review menu in advance to ensure all menu	06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation and interview with Resident 52 on 5/3/2023 at 1:42 p.m. indicated that she was served cream of potato soup, grilled cheese, and canned pineapple. She indicated that her meal was missing a muffin. She stated she feels like that the kitchen just makes whatever they want, and they are always out of something. The lunch menu for 5/5/2023 indicated the meal would consist of taco salad, sour cream and salsa, tortilla chips, and tropical fruit salad. An observation of the kitchen staff on 5/5/2023 at 11:45 a.m., Dietary Staff 3 instructed the other staff to put the tortilla chips up because they were not on the menu. An observation on 5/5/2023 at 12:10 p.m. indicated that hall trays being passed consisted of taco salad mandarin oranges. An interview with Resident 95 on 5/5/2023 at 1:43 p.m., indicated she did not receive tortilla chips with her lunch. An interview with Resident 52 on 5/5/2023 at 1:45 p.m. indicated she did not receive tortilla chips with her lunch. An interview with the Dietary Manager on 5/9/2023 at 1:45 p.m. indicated she was not sure why 5/3/2023's lunch meal was not as indicated on the menu, but on 5/5/2023 the staff omitted the tortilla chips due to it being the staff's first-time making taco salad and she was nervous. She was not sure why the tropical fruit salad was substituted for mandarin oranges. It is the expectation that they would follow the menu as provided unless she was unable to get an item, then a substitution would be made.		items are present. • Culinary Manager to review any menu alterations with RD in advance for approval. • Residents to be notified of menu changes in advance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • Recipe Compliance QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. • If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 6/15/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-20(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to accurately complete a weekly skin assessment for 1 of 36 residents reviewed for complete and accurate records. (Resident 73) Findings include:	F 0842	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • A skin assessment was completed on resident 73 and accurately documented in a	06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 73's record was reviewed, on 5/4/23, at 2:04 p.m. The record indicated Resident 73 had diagnoses that included, but were not limited to, stroke, dementia, type 2 diabetes mellitus, weakness and generalized muscle weakness. A Significant Change Minimum Data Set assessment, dated 3/9/23, indicated Resident 73 was moderately cognitively impaired, required set up and supervision for activities of daily living, was not at risk for developing pressure ulcers, and had no pressure ulcers. A care plan was in place, dated 4/26/2023, with a problem that resident has impaired skin integrity due to pressure wound to left buttock. She is at risk for skin breakdown due to impaired tissue perfusion from type 2 diabetes, history of wound to coccyx, and decline in mobility due to stroke. A progress note, dated 4/26/2023 at 2:27 p.m., indicated: "Res (resident) noted to have new pressure ulcer to left buttock. Sig (significant) change assessment has been scheduled." A weekly skin assessment, dated 4/27/23, indicated Resident 73 had no areas of skin integrity alterations: no skin issues, including skin tears, open areas, or bruises. She is compliant with being turned and repositioned, had a specialty mattress on her bed and a pressure reducing cushion in her wheelchair. On 5/05/23 at 1:45 p.m., a dressing change was observed with RN 4 and LPN 5. LPN 5 removed the old dressings from the left buttocks, cleansed the area with normal saline and patted dried it with gauze. There were 2 areas, almost side by side, that were shallow, and she dressed both of them		weekly skin assessment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents have the potential to be affected by the alleged deficient practice. • Audit to be completed by DNS or designee to ensure that residents with identified skin areas have accurate documentation on weekly skin assessments. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • All LPN's and RN's to be educated on skin management program, specifically accurate documentation of identified areas in weekly skin assessments by DNS or designee by 6/15/23. • DNS/designee will review residents with identified skin areas to ensure that weekly skin assessments accurately reflect identified areas. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with the maxsorb and covered them with a dressing. Both areas had a small, slightly darker center area and the surrounding area had whitened areas and reddened areas with no open areas. On 5/8/23, at 2:12 p.m., the Director of Nursing Services indicated the nurses were not putting in the existing skin conditions and they have done education about documenting the existing areas on the weekly skin assessments. She said they can document in wound management, but they should be putting it on the existing skin conditions part of the weekly skin assessments also. Wound management notes indicated two stage 3 pressure ulcers on her left buttock, that were identified on 4/25/23 at 3:02 p.m. One pressure ulcer measured 0.5 length, 0.6 width, 0.1 depth, had no drainage, or tunneling and had granulated tissue type. The second pressure ulcer measured 0.5 by 0.4, was a stage 2, and had no drainage or tunneling, and the surrounding skin was reddened. A Policy for "Skin Management Program" was provided by the Director of Nursing Services on 5/9/23 at 3:00 p.m. The policy included, but was not limited to, "Procedure for Alterations in Skin Integrity - Pressure and Non-Pressure...5. b) The wound nurse/designee will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day. The 'observed' date indicated on the Wound Management document is the date the wound was assessed,, including but not limited to measurements, staging, condition of tissue, and drainage...."		meetings being held monthly, and is overseen by the Executive Director. • Wound and Skin Management QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. • If Threshold of 90% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 6/15/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-50(a)(1) 3.1-50(a)(2)			