STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTH AND WELLNESS CENTER	10820 PARK PLACE, SAINT JOHN, , 46373

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 468260. Intake 468260 - State deficiencies related to the allegations are cited at R0002 and R0241. Survey date: March 3, 2026 Facility number: 017974 Residential Census: 25 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/10/26.	R 0000	The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these findings.	

R 0002	Scope of Residential Care - Offense 410 IAC 16.2-5-0.5(b) (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule. Based on record review and interview, the facility failed to ensure a resident was not provided comprehensive nursing care related to wound care treatment for a resident who resided in the Assisted Living Memory Care Unit for 1 of 2 residents reviewed for wound care treatments. (Resident B) Finding includes: Resident B's closed record was reviewed on 3/3/26 at 10:20 a.m. The diagnoses included, but were not limited to Alzheimer's disease and dementia. A Health Status Progress Note, dated 6/3/25 at 9:25 p.m., indicated an area was observed on the gluteal cleft that was purple black in color with redness surrounding the area. The purple black area measured 1 centimeter (cm) by 3 cm. The Director of Nursing (DON) was made aware of the area. A Physician's Order, dated 6/5/25 indicated the gluteal cleft	R 0002	**Corrective actions taken for those residents alleged to have been affected by the alleged deficient practice:** Resident B no longer resides at facility, no further corrective action will be taken. **Actions taken to identify other residents that have the potential to be affected by the alleged deficient practice:** All AL residents with current wounds are at risk of the alleged deficient practice. All AL residents with current wounds have had records reviewed to ensure that comprehensive care is only being provided by home healthcare. The care of no other current residents had concerns identified related to this alleged deficiency. **The measures the facility will take to ensure the problem will be corrected and will not recur:** All licensed clinical personnel have been re-educated regarding only having home healthcare provide comprehensive services to AL residents. DON or designee will audit all AL residents receiving wound care services through home healthcare to ensure comprehensive care is exclusively provided by home healthcare services twice	03/18/2026

	area was to be cleansed, patted dry, and Calmoseptine lotion was to be applied after toileting every shift until the area was healed. The CNA's may apply the Calmoseptine to the area. A Skin/Wound Progress Note, dated 6/8/25 at 12:23 p.m., indicated a family member voiced a concerns about the resident's wounds. The right coccyx wound measured 4 cm by 3 cm, had a scant amount of blood with no odor, and the wound base was unable to be identified. Calmoseptine cream was applied. The left gluteal fold wound measured 0.5 cm x 1 cm. there was no bleeding, no odor and the wound base appeared to be at the dermis. "...family stated that wound is worsening - worth noting..." A Family Communication Note, dated 6/13/25 at 1:08 p.m., indicated the family was notified per telephone that the wound to the right ilium was 4 cm x 2 cm x 0.1 cm (depth), with 100% yellow slough. There was a scant amount of serosanguinous drainage. The wound was cleansed, patted dry, hydrofera blue (advanced wound care dressing) and an occlusive dressing was applied to the area. A foam dressing was applied as preventative to the sacrum and left ischium. The moisture associated skin		weekly for 3 months. **Quality assurance plans to monitor facility performance to make sure corrections are achieved:** Audit tools will be reviewed and discussed by the Interdisciplinary Team through Quality Assurance process for 3 months. After 3 months, any issues identified by Interdisciplinary Team will be reviewed for further reinstitution of audits.	

	damaged area on the gluteal cleft was cleaned and Calmoseptine ointment was applied. The family member preferred the the facility staff continued to care for the wound. A Physician's Order, dated 6/13/25, indicated the right ilium wound was to be cleansed with normal saline, patted dry, and Hydrofera blue and a occlusive wound dressing was to be applied on Tuesday's, Friday's, and as needed. A facility pressure wound policy, dated 8/1/23 and received from the DON as current, indicated residency requirements are followed for a resident with a pressure wound stage III (full thickness skin loss or necrosis). Wound care services may be provided in conjunction with a third-party provider such as home health, hospice, or wound care clinic. During an interview on 3/3/26 at 1:20 p.m., the DON indicated the wound had declined and the nurse should not have done the treatment on the area. When the nurse was unable to determine what the wound base looked like, the wound would have been classified as a stage III or above and Home Health should have been notified. She indicated staff nurses could not complete wound care for			

	wounds more than a stage II (superficial wound). This citation relates to Intake 468260.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure residents' wounds were assessed, physicians were notified, and treatments for the wounds were obtained in a timely manner resulting in deterioration of the wounds for 2 of 2 residents reviewed for pressure areas. (Residents B and E) Findings include: 1. Resident B's closed record was reviewed on 3/3/26 at	R 0036	**Corrective actions taken for those residents alleged to have been affected by the alleged deficient practice:** Resident B no longer resides at facility, no further corrective action to be taken. Wound assessment and treatment for resident E have been reported to primary care provider and responsible party. **Actions taken to identify other residents that have the potential to be affected by the alleged deficient practice:** All residents with identified wounds are at risk of same alleged deficient practice. Skin assessments were performed on all AL residents to identify any new wounds or changes in existing wounds. No further residents were identified as having new skin issues. **The measures the facility will take to ensure the problem will be corrected and will not recur:** All licensed clinical personnel have been re-educated regarding wound assessments	03/18/2026

	10:20 a.m. The diagnoses included, but were not limited to Alzheimer's disease and dementia. The resident resided on the Assisted Living Memory Care Unit and was admitted on to the facility on 5/26/25. An Admission Assessment, dated 5/26/25, indicated there were no wounds that required wound care. A Service Plan, dated 6/1/25, indicated a deep tissue injury (DTI) (a serious, often rapidly progressing pressure ulcer) was present on the right gluteal fold. The interventions included she would be assisted with turning while in bed and a chair cushion was in place. There was no assessment of the DTI on 6/1/25, no physician notification and no treatment initiated on 6/1/25. A Health Status Progress Note, dated 6/3/25 at 9:25 p.m., indicated an area was observed on the gluteal cleft that was purple black in color with redness surrounding the area. The purple black area measured 1 centimeter (cm) by 3 cm. The Director of Nursing (DON) was made aware of the area. A Physician's Order, dated 6/5/25 indicated the gluteal cleft area was to be cleansed, patted dry, and Calmoseptine lotion		and immediate notification to primary care provider and responsible party of any change of condition, including deterioration of wounds. Skin observations for AL residents will be completed weekly concurrent with scheduled shower days, and any change of condition or new orders must be communicated immediately to primary care provider and responsible party. DON or designee will review audits twice weekly for 3 months on completed shower and skin sheets to ensure any changes of condition are reported in a timely manner to primary care provider and responsible party, and that appropriate treatments were initiated. On existing, previously identified wounds, DON or designee will reassess wound condition weekly for deterioration or improvement. Any changes will be reported immediately to primary care provider and responsible party. Any appropriate wound treatment changes will be made in accordance with relevant physician order. **Quality assurance plans to monitor facility performance to make sure corrections are achieved:** Audit tools will be reviewed and discussed by the Interdisciplinary Team through	

	was to be applied after toileting every shift until the area was healed. The CNA's may apply the Calmoseptine to the area. The Treatment Administration Record, dated 6/2025, indicated the Calmoseptine cream had been applied to the gluteal cleft area every shift after toileting daily. There was no documentation that indicated the wound had declined in status nor of the new area found on the right coccyx. A Skin/Wound Progress Note, dated 6/8/25 at 12:23 p.m., indicated a family member voiced a concerns about the resident's wounds. The right coccyx wound measured 4 cm by 3 cm, had a scant amount of blood with no odor, and the wound base was unable to be identified. Calmoseptine cream was applied. The left gluteal fold wound measured 0.5 cm x 1 cm. there was no bleeding, no odor and the wound base appeared to be at the dermis. "...family stated that wound is worsening - worth noting..." There was no documentation the Physician had been notified of the changes in the wound status or of the new wound on the right coccyx. A Family Communication Note, dated 6/13/25 at 1:08 p.m.,		Quality Assurance process for 3 months. After 3 months, any issues identified by Interdisciplinary Team will be reviewed for further reinstitution of audits.	

indicated the family was notified per telephone that the wound to the right ileum was 4 cm x 2 cm x 0.1 cm (depth), with 100% yellow slough. There was a scant amount of serosanguinous drainage. The wound was cleansed, patted dry, hydrofera blue (advanced wound care dressing) and an occlusive dressing was applied to the area. A foam dressing was applied as preventative to the sacrum and left ischium. The moisture associated skin damaged area on the gluteal cleft was cleaned and Calmoseptine ointment was applied. The family member preferred the facility staff continued to care for the wound.

During an interview on 3/3/26 at 11:25 a.m., a Hospital Medical Records employee indicated the resident's record contained a wound note from 6/16/26 that stated the area on the right iliac was large and the wound had first been observed on 6/14/26 when the resident was admitted to the hospital. Multiple attempts to fax the records were unsuccessful.

During an interview on 3/3/26 at 1:20 p.m., the DON indicated she had assessed the resident prior to admission and there had been a small open area on the buttock. The family had informed her the area was

present. She indicated the area was less than a dime size and was a stage II (superficial). There was no skin assessment completed on admission and no treatment ordered for the area on admission. The Wound Nurse/ADON was to assess the resident's skin on admission and ensure treatments were put into place if needed. The pressure areas had declined and there was no change in treatments until the day prior to the transfer to the hospital. The family had shown the DON pictures of the wounds after discharge and the areas "looked bad."

2. Resident E's record was reviewed on 3/3/26 at 2:35 p.m. The diagnoses included, but were not limited to, diabetes mellitus and end stage renal disease.

A Communication Progress Note, dated 12/8/25 at 11:06 a.m., indicated the resident had a complaint of a sharp pain in the left heel. There was a scab present on the left heel, no signs of infection. Double thickness of Sherpa was added to the left shoe as a temporary solution and staff encouraged the resident to purchase diabetic shoes to allow the fit to be adjustable due to swelling.

The Physician had not been notified of the scab on the

resident's left heel and no treatment was obtained for the area on the heel.

There was no assessment completed on the left heel from 12/8/25 through 1/30/25 and no Service Plan for the wound on the heel was initiated.

An assessment, dated 1/30/26 and completed by a Clinical Wound Specialist, indicated there was a left heel pressure ulcer. The measurements were 2 cm by 2 cm and the depth was unable to be determined. It was a full thickness wound with moderate amount of exudate and was 100% necrotic. The treatment order was to cleanse the area with a wound cleanser, pack the wound lightly with a collagen pad (wound dressing). A negatively charged fiber (NCF) debridement dressing was to be applied to the wound bed and then covered with a dressing daily for 23 days.

The wound orders were not transcribed and the treatment had not been completed per the Clinical Wound Specialist.

A Start of Care Note from Home Health, dated 2/5/26, indicated a stage II (superficial) pressure ulcer to the left heel. The wound measured Length 2.0 cm by Width 2.2 cm and 0.4 cm depth. There was 50% slough present with serous drainage. The

	treatment was to cleanse the area, and apply Urogstat (debriding agent) to the wound bed and cover with foam dressing. Home Health would complete the dressing changes twice a week. A Pressure Staging Guide, found at "www.in.gov/health/files/Pressure_Ulcer_", indicated the following: - STAGE II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. - STAGE III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.			

During an interview on 3/3/26 at 3:13 p.m. with the DON and ADON, the ADON indicated it was her responsibility to monitor wounds. The DON indicated there had not been an assessment completed on the left heel wound from 12/8/25 to 1/30/26. The resident required assistance with bathing and care and there had been documentation that indicated there was a change in the wound status. The Physician should have been notified of the area on the heel on 12/8/25.

During an interview on 3/3/26 at 3:57 a.m., the ADON indicated Home Health for wound care started on 2/5/26. She indicated they were doing the treatments, but the nurses at the facility had initialed the treatments had been completed. She was first aware of the area on the heel on 1/30/26 and there had been no assessments completed from 12/8/25 to 1/30/26.

A facility pressure wound policy, dated 8/1/23 and received from the DON as current, indicated the Physician and responsible party were to be notified of pressure and a plan for treatment was to be established. The plan of care was to be updated to reflect the resident's skin condition.

	This citation relates to Intake 468260.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURENathan Wolf	TITLEExecutive Director	(X6) DATE03/17/2026