STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARMEL	301 EXECUTIVE DR, CARMEL, , 46032

(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 Complaints IN00453749 and IN00454251. Complaint IN00453749-No deficiencies related to the allegations are cited. Complaint IN00454251-State deficiencies related to the allegations are cited at R0052. Survey dates: February 27 and 28, 2025 Facility number: 010416 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on March 7, 2025.	R 0000	The following Plan of Correction for Brookdale Carmel regarding the statement of Deficiencies dated February 28th, 2025. This Plan of Correction is not to be constructed as an admission of our agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	Resident C	03/21/2025

	free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from neglect when new pressure wounds were not appropriately identified, assessed and reported to the physician and to ensure licensed nurses did not treat pressure ulcers without a physician's order for 1 of 3 residents reviewed for neglect. (Resident C) Resident C was hospitalized, and pressure ulcers were identified by hospital personnel upon admission to her bilateral heels, bilateral trochanter areas (hips), sacrum (buttocks), coccyx/intragluteal cleft area (tailbone), left elbow, right inner thigh, right iliac crest (pelvis) and right flank area (over the ribs). Findings include: In an email, dated 2/23/25, Resident C's family member indicated around the first of January 2025, a CNA notified		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident C left the community on 01.28.2025 and never returned. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Health & Wellness Director completed skin audit of all residents starting on 02.28.2025 finish audit on 03.03.2025 with no areas identified. Health & Wellness Director completed a second(2nd) skin audit started 03.12.2025 and was completed 03.13.2025 with no new areas identified. Area Health & Wellness Director or designee will complete another skin audit starting 3.17.2025 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Health & Wellness Director re-training with Nurses on 03.07.2025 on skin report cards, skin management, skin documentation, physician orders, and change in condition. Health & Wellness Director completed re-training with nursing assistants on 03.13.2025 on reporting a change in condition and utilization of skin report cards. District Director of Clinical Services re-trained the Executive Director	

	her Resident C had some bruising on her hips. Resident C's family member had observed the areas on the resident's hips which looked like bruises with a small amount of chaffing. On January 20, 2025, the resident's family member visited Resident C and observed her being placed in her wheelchair. The family member noticed the resident's incontinence pad had a brownish spot about the size of a cup. The resident had a bandage on her right hip, which was "oozing" and there was a "putrid smell" coming from her hip. She had the CNA peel back the bandage and observed a wound on the resident's right hip, which was "pus-filled and red." The family member indicated to the CNA that the resident needed to see a physician and the CNA went and got the nurse. The nurse brought in wound cleaning and bandage supplies and dressed the wound. The family member told the nurse Resident C needed to see a physician due to the way her hip looked and smelled. The nurse indicated she would discuss the wound with the head nurse and wound care would be called. On January 24, 2025, the family member asked the nurse on duty if she had seen the resident's wound, and the nurse indicated wound care would take care of it. On January 28th,		and Health and Wellness Director on open area documentation policy and skin integrity documentation policy on 03.11,2025 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place: To assist with ongoing compliance, the Health & Wellness Director or designee will complete ten (10) random resident skin assessments monthly for six (6) months. Any skin issues identified will be reported to the Executive Director or designee. Health & Wellness Director or designee will review the 24-hour report summary Monday thru Friday weekly for six (6) months. Any issues identified will be reported to the Executive Director or designee. By what date the systemic change will be completed: 03.21.2025	

2025, the family member observed the dressing to the hip was "oozing" again and smelled. The resident went to the emergency room where the family discovered Resident C had pressure ulcers on her right hip, bilateral heels, elbows, and bilateral ankles. She was placed on hospice and her wounds would probably never heal.

During a confidential phone interview, the interviewee indicated Resident C's had other wounds on her heels, ankles, and elbows which were discovered after she was admitted to the hospital. Resident C had a wound vac placed on some of her wounds.

During an interview, on 2/27/25 at 10:03 a.m., the Director of Wellness indicated Resident C only had wounds on her bilateral hips. She did not have wounds any place else on her body. She attempted to set up an appointment with a home health care agency for wound care to the resident's bilateral hip wounds, but that home health care agency did not accept her insurance. She was trying to get another home health care agency to admit her, but she did not prior to a family member requesting the resident be sent to the emergency room on 2/28/25.

The clinical record for Resident

C was reviewed on 2/28/25 at 12:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, dementia with anxiety, osteoporosis, and urinary tract infection.

A physician's order, dated 11/02/24, indicated to apply house barrier cream to bilateral buttocks, coccyx and peri-area every shift and as needed with incontinent episodes. The cream may be kept at bedside to be reapplied as needed and every shift.

The electronic Medication Administration Record and electronic Treatment Administration Record, dated 11/1/24 to 11/30/24, 12/1/24 to 12/31/24 and 1/1/25 to 1/28/25, indicated there were no treatment orders listed for any wounds on Resident C.

A nursing progress note, dated 12/17/24 at 1:14 p.m., signed by LPN 5, indicated the resident had a skin tear on her left elbow which she cleaned with normal saline, patted dry, applied antibiotic ointment, and covered with a Band-Aid.

A nursing progress note, dated 12/24/24 at 9:49 a.m., signed by LPN 5, indicated a CNA notified her that the resident had redness to her right hip. The resident was laid down on her

right side at night and was not able to turn herself without assistance. The skin was intact and cool to the touch. The Director of Wellness and the Nurse Practitioner was notified.

A skin observation form, dated 12/24/24, indicated the resident had redness on her right hip and a healing skin tear to her left elbow. There was no nurse signature on this form.

A nursing progress note, dated 12/26/24 at 2:03 p.m., signed by LPN 5, indicated the resident's right hip was discolored and an intact blister remained. There was no indication that the Nurse Practitioner or physician was notified regarding the blister to her right hip.

A skin observation form, dated 12/31/24, signed by LPN 6, indicated the resident's right hip was reddened with an intact and fluid filled blister, and she had a healing skin tear to her left elbow.

A skin observation form, dated 1/7/25, signed by LPN 6, indicated the resident's right hip had a blister on it, her peri-area was reddened, and she had a healing skin tear on her left elbow which was 100% scabbed.

A skin observation form, dated 1/14/25, signed by LPN 6, indicated the resident's bilateral

hips were reddened, the right hip had a blister on it, her peri-area was reddened and calmoseptine (an over-the-counter cream used to treat minor skin irritations) was applied. Her left elbow had a healing skin tear which was 100% scabbed.

A nursing progress note, dated 1/17/25 at 10:31 a.m., signed by LPN 5, indicated the Nurse Practitioner visited the resident. There were no orders written for wound treatments for her bilateral hip skin conditions.

A nursing progress note, dated 1/17/25 at 3:21 p.m., signed by LPN 4, indicated the resident had redness to her left hip with a small scab in the center of the hip. The area was cleansed. Skin prep was applied, then calmoseptine was applied over the skin prep per nursing measures. LPN 4 observed redness and an abrasion without drainage to the resident's lower back area. The area was cleaned, patted dry, and a non-adherent dressing was applied per nursing measures. LPN 4 observed redness to the right hip with a small amount of serosanguinous drainage. The area was cleaned, patted dry, and then a padded adherent dressing was applied per nursing measures.

A nursing progress note, dated

1/18/25 at 3:20 p.m., signed by LPN 4, indicated the dressings were changed to the resident's bilateral hips and lower back. The skin wounds were placed in the medical doctors' book for the wounds to be evaluated by the Nurse Practitioner or the physician on the next visit.

A nursing progress note, dated 1/20/25 at 2:56 p.m., signed by LPN 4, indicated she spoke to the resident's Power of Attorney (POA) regarding the skin on the right hip, buttocks, and lower back area and the option to have home health care come to the facility to evaluate and treat the wounds. The POA was interested in having home health care evaluate and treat the wounds. LPN 4 cleaned the areas and then treated them according to nursing measures. Resident C had a 99.0-degree F (Fahrenheit) temperature.

A skin observation form, dated 1/21/25, signed by LPN 6, indicated the resident had redness to her peri-area which she applied calmoseptine ointment, redness to her left hip which she applied skin prep and a blister to her right hip which she applied a dressing (no specific dressing type was documented).

A nursing note, dated 1/25/25 at 3:56 p.m., signed by LPN 4, indicated she had cleaned,

applied a treatment and dressing to Resident C's bilateral hips per nursing measure.

A nursing note, dated 1/26/25 at 2:28 p.m., signed by LPN 4, indicated she cleaned and treated Resident C's open areas to the right hip. She observed a moderate amount of serosanguineous drainage to the right hip during the dressing change. The left hip had redness with a small crusty scab in the center. Skin prep was applied to the left hip. The dressing was not changed to the lower back/sacrum area because it was clean, dry, and intact.

A nursing note, dated 1/28/25 at 7:01 p.m., signed by LPN 7, indicated at 6:35 p.m., the POA came to visit the resident. Resident C's blood pressure was 71/43 and she had no urine output since 1/27/25 per the CNA report. Resident C was sent to the ER per the POA's request.

A document, titled "ER MD Exam and Disposition," dated 1/28/25 at 9:15 p.m., indicated the physician reviewed the resident's wound ulcerations on the right iliac crest, which appeared to have some central brownish hue and some surrounding mild redness, but no definitive evidence of

secondary infection. It looked like it needed to be derided. The presacral wounds looked to be more of a stage II with proud flesh and a central area which had a dressing over it. The note indicated case management would need to arrange for a definitive wound care consultation and arrangements when she returned to her facility.

A document, titled "Adult assessment Intervention," dated 1/28/25 at 6:56 p.m., indicated Resident C had the following wounds:

a. A right inner thigh wound which was described as excoriation. The wound base was reddened, and the wound was present when the resident was admitted to the hospital.

b. A wound on her right flank area (upper back area) which was an evolving Deep Tissue Injury (DTI). It was reddened, opened, and had moist drainage. It was present on admission to the hospital.

c. A wound to her intergluteal cleft which was a stage 3. It was opened, reddened, and had moist drainage. It was present on admission to the hospital.

d. A pressure wound to her left heel, which was an evolving stage III pressure wound. It was open, reddened, and had moist

drainage. It was present on admission to the hospital.

e. A pressure wound to her left elbow which was a stage 3 wound. It was open, reddened, and had moist drainage. It was present on admission to the hospital.

A document, titled "Wound/Skin Evaluation," dated 1/29/25 at 3:45 p.m., indicated Resident C had the following wound evaluation:

a. A left heel pressure wound which was an evolving suspected DTI. The wound was 35% black and gray eschar (dead tissue), 60% pink tissue, and 5% epithelial tissue with minimal tan and serosanguineous drainage. The peri-wound tissue was reddened, but blanched. The wound measured 4.5 cm (centimeters) x 3.5 cm x 0.1 cm.

b. A left trochanter (hip) pressure wound which was 50% black and gray eschar and 50% tan and yellow slough (fibrous tissue) with very minimal serosanguineous drainage. The peri-wound had redness, but blanched. The wound measured 3.0 cm x 2.0 cm x 0.1 cm and was staged as unstageable.

c. A sacral spine pressure wound which was 100% tan and yellow slough with minimal drainage. The peri-wound was

reddened and friable, but blanched. The wound measured 6.0 cm x 3.5 cm x 0.1 cm and was staged as unstageable.

d. A intergluteal cleft wound caused by friction/MASD (Moisture Associated Skin Disorder), which was 85% pink and red tissue and 15% gray slough tissue and had copious amounts of drainage. The peri-wound was reddened, but blanched. The wound measured 5.0 cm x 2.0 cm x 0.1 cm. and was staged as unstageable.

e. A right trochanter (hip) pressure wound which was 100% wet tan slough with copious amounts of drainage. The peri-wound was reddened, but it blanched. The wound measured 4.5 cm x 2.0 cm and was staged as unstageable.

f. A right iliac crest pressure wound which was 100% black eschar with minimal drainage. The wound measured 2.5 cm x 1.5 cm and was staged as unstageable.

g. A right flank pressure wound which was 80% pink tissue and 20% pink and white tissue with minimal drainage. The peri-wound was reddened, but blanched. The wound measured 4.5 cm x 3.0 cm x 0.1 cm. and was staged as an evolving suspected DTI.

During an interview, on 2/28/25

at 1:12 p.m., CNA 3 indicated she would bathe, feed, and dress Resident C. She had observed wounds on the resident's right heel, coccyx area, bilateral hips, bilateral elbows, and a bruise on her chest which came and went. She had notified LPN 3, 4 and 5 regarding the wounds. The three nurses applied dressings and cream to her hips and coccyx area. The resident only took sips of liquids and would not open her mouth to eat.

During an interview, on 2/28/25 at 1:30 p.m., LPN 4 indicated she passed medications to Resident C and treated her wounds by placing calmoseptine on her bilateral hips, with a dressing over the wounds. After the wounds opened, she cleaned them with warm water and soap and placed a dry dressing on the wounds. The resident's lower back started to get red. She may have placed the information about the wounds in the doctor's book for the Nurse Practitioner (NP) to see at the next visit. She never specifically phoned the physician or NP for orders for the resident's wounds. She did not know about any other wounds besides the resident's hip wounds.

During an interview, on 2/28/25 at 1:45 p.m., LPN 5 indicated she gave Resident C her

medications daily when she was scheduled to work upstairs. She knew the resident had a bruise on one of her hips. She was not told about any other wounds. If she had known about any wounds, she would have gotten an order to dress the wounds.

During an interview, on 2/28/25 at 1:54 p.m., LPN 6 indicated she gave Resident C her medications, fed her, checked on her, and helped the CNAs transfer her. She knew the resident had a wound to her bilateral hips. She had an abrasion looking area to her lower back. The nurses were covering the wounds with a non-adherent dressing to the weeping wound. LPN 6 had no idea when the dressing needed changed because there was no order for the dressing change. It was changed when it needed changed such as it was leaking. She never called the NP or the physician to notify them of Resident C's wounds or to get an order to treat her wounds. LPN 6 indicated she just tried to treat the "oozing wound." She was never told about any other wounds besides the hip wounds by a CNA.

A current facility policy, titled "Skin Integrity Documentation Policy," dated as revised 5/2023 and provided by the Director of Wellness on 2/28/25 at 12:30 p.m., indicated "...Skin Changes

	1. The associate/caregiver should report skin changes if noted for residents who are receiving assistance with a bath or shower. 2. The Health and Wellness Director (HWD) or designee should: a. Review the received skin report card from a care associate, take appropriate action and follow the Change of Condition policy...Notify the physician/healthcare provider (HCP) and family of the skin concern as soon as possible. c. Notify the District Director of Clinical Services (DDCS) if a delay in treatment or orders occurs d. Apply dry dressing to wound or pressure injury until physician/HCP orders are received. 3. As indicated, refer wound care needs to Home Health/Hospice for treatment after obtaining physician approval and/or order. Pressure injuries will be staged by a third-party provider, registered nurse or physician/HCP 4. Record the third-party provider's name and their staging of the wound...and update the resident's service plan as indicated. 5. Monitor treatment and progress. Any changes to the wound or lack of improvement should be reported to the physician/Health Care Provider (HCP). 6. Complete a Brookdale Automated Incident Reporting System (BAIRS) Report for Stage 3, 4 or unstageable pressure injury. Document pressure injury under			

a. nature of incident/miscellaneous/other section and b. type of injury/impairment/open area or other if skin tissue is the result of an incident, injury, fall or is determined unstageable...."

This citation relates to Complaint IN00454251.

Based on interview and record review, the facility failed to ensure a resident was free from neglect when new pressure wounds were not appropriately identified, assessed and reported to the physician and to ensure licensed nurses did not treat pressure ulcers without a physician's order for 1 of 3 residents reviewed for neglect. (Resident C) Resident C was hospitalized, and pressure ulcers were identified by hospital personnel upon admission to her bilateral heels, bilateral trochanter areas (hips), sacrum (buttocks), coccyx/intragluteal cleft area (tailbone), left elbow, right inner thigh, right iliac crest (pelvis) and right flank area (over the ribs).

Findings include:

In an email, dated 2/23/25, Resident C's family member indicated around the first of January 2025, a CNA notified her Resident C had some bruising on her hips. Resident

C's family member had observed the areas on the resident's hips which looked like bruises with a small amount of chaffing. On January 20, 2025, the resident's family member visited Resident C and observed her being placed in her wheelchair. The family member noticed the resident's incontinence pad had a brownish spot about the size of a cup. The resident had a bandage on her right hip, which was "oozing" and there was a "putrid smell" coming from her hip. She had the CNA peel back the bandage and observed a wound on the resident's right hip, which was "pus-filled and red." The family member indicated to the CNA that the resident needed to see a physician and the CNA went and got the nurse. The nurse brought in wound cleaning and bandage supplies and dressed the wound. The family member told the nurse Resident C needed to see a physician due to the way her hip looked and smelled. The nurse indicated she would discuss the wound with the head nurse and wound care would be called. On January 24, 2025, the family member asked the nurse on duty if she had seen the resident's wound, and the nurse indicated wound care would take care of it. On January 28th, 2025, the family member observed the dressing to the hip

was "oozing" again and smelled. The resident went to the emergency room where the family discovered Resident C had pressure ulcers on her right hip, bilateral heels, elbows, and bilateral ankles. She was placed on hospice and her wounds would probably never heal.

During a confidential phone interview, the interviewee indicated Resident C's had other wounds on her heels, ankles, and elbows which were discovered after she was admitted to the hospital. Resident C had a wound vac placed on some of her wounds.

During an interview, on 2/27/25 at 10:03 a.m., the Director of Wellness indicated Resident C only had wounds on her bilateral hips. She did not have wounds any place else on her body. She attempted to set up an appointment with a home health care agency for wound care to the resident's bilateral hip wounds, but that home health care agency did not accept her insurance. She was trying to get another home health care agency to admit her, but she did not prior to a family member requesting the resident be sent to the emergency room on 2/28/25.

The clinical record for Resident C was reviewed on 2/28/25 at 12:30 p.m. The diagnoses

included, but were not limited to, diabetes mellitus, chronic kidney disease, dementia with anxiety, osteoporosis, and urinary tract infection.

A physician's order, dated 11/02/24, indicated to apply house barrier cream to bilateral buttocks, coccyx and peri-area every shift and as needed with incontinent episodes. The cream may be kept at bedside to be reapplied as needed and every shift.

The electronic Medication Administration Record and electronic Treatment Administration Record, dated 11/1/24 to 11/30/24, 12/1/24 to 12/31/24 and 1/1/25 to 1/28/25, indicated there were no treatment orders listed for any wounds on Resident C.

A nursing progress note, dated 12/17/24 at 1:14 p.m., signed by LPN 5, indicated the resident had a skin tear on her left elbow which she cleaned with normal saline, patted dry, applied antibiotic ointment, and covered with a Band-Aid.

A nursing progress note, dated 12/24/24 at 9:49 a.m., signed by LPN 5, indicated a CNA notified her that the resident had redness to her right hip. The resident was laid down on her right side at night and was not able to turn herself without

assistance. The skin was intact and cool to the touch. The Director of Wellness and the Nurse Practitioner was notified.

A skin observation form, dated 12/24/24, indicated the resident had redness on her right hip and a healing skin tear to her left elbow. There was no nurse signature on this form.

A nursing progress note, dated 12/26/24 at 2:03 p.m., signed by LPN 5, indicated the resident's right hip was discolored and an intact blister remained. There was no indication that the Nurse Practitioner or physician was notified regarding the blister to her right hip.

A skin observation form, dated 12/31/24, signed by LPN 6, indicated the resident's right hip was reddened with an intact and fluid filled blister, and she had a healing skin tear to her left elbow.

A skin observation form, dated 1/7/25, signed by LPN 6, indicated the resident's right hip had a blister on it, her peri-area was reddened, and she had a healing skin tear on her left elbow which was 100% scabbed.

A skin observation form, dated 1/14/25, signed by LPN 6, indicated the resident's bilateral hips were reddened, the right hip had a blister on it, her

peri-area was reddened and calmoseptine (an over-the-counter cream used to treat minor skin irritations) was applied. Her left elbow had a healing skin tear which was 100% scabbed.

A nursing progress note, dated 1/17/25 at 10:31 a.m., signed by LPN 5, indicated the Nurse Practitioner visited the resident. There were no orders written for wound treatments for her bilateral hip skin conditions.

A nursing progress note, dated 1/17/25 at 3:21 p.m., signed by LPN 4, indicated the resident had redness to her left hip with a small scab in the center of the hip. The area was cleansed. Skin prep was applied, then calmoseptine was applied over the skin prep per nursing measures. LPN 4 observed redness and an abrasion without drainage to the resident's lower back area. The area was cleaned, patted dry, and a non-adherent dressing was applied per nursing measures. LPN 4 observed redness to the right hip with a small amount of serosanguinous drainage. The area was cleaned, patted dry, and then a padded adherent dressing was applied per nursing measures.

A nursing progress note, dated 1/18/25 at 3:20 p.m., signed by LPN 4, indicated the dressings

were changed to the resident's bilateral hips and lower back. The skin wounds were placed in the medical doctors' book for the wounds to be evaluated by the Nurse Practitioner or the physician on the next visit.

A nursing progress note, dated 1/20/25 at 2:56 p.m., signed by LPN 4, indicated she spoke to the resident's Power of Attorney (POA) regarding the skin on the right hip, buttocks, and lower back area and the option to have home health care come to the facility to evaluate and treat the wounds. The POA was interested in having home health care evaluate and treat the wounds. LPN 4 cleaned the areas and then treated them according to nursing measures. Resident C had a 99.0-degree F (Fahrenheit) temperature.

A skin observation form, dated 1/21/25, signed by LPN 6, indicated the resident had redness to her peri-area which she applied calmoseptine ointment, redness to her left hip which she applied skin prep and a blister to her right hip which she applied a dressing (no specific dressing type was documented).

A nursing note, dated 1/25/25 at 3:56 p.m., signed by LPN 4, indicated she had cleaned, applied a treatment and dressing to Resident C's

bilateral hips per nursing measure.

A nursing note, dated 1/26/25 at 2:28 p.m., signed by LPN 4, indicated she cleaned and treated Resident C's open areas to the right hip. She observed a moderate amount of serosanguineous drainage to the right hip during the dressing change. The left hip had redness with a small crusty scab in the center. Skin prep was applied to the left hip. The dressing was not changed to the lower back/sacrum area because it was clean, dry, and intact.

A nursing note, dated 1/28/25 at 7:01 p.m., signed by LPN 7, indicated at 6:35 p.m., the POA came to visit the resident. Resident C's blood pressure was 71/43 and she had no urine output since 1/27/25 per the CNA report. Resident C was sent to the ER per the POA's request.

A document, titled "ER MD Exam and Disposition," dated 1/28/25 at 9:15 p.m., indicated the physician reviewed the resident's wound ulcerations on the right iliac crest, which appeared to have some central brownish hue and some surrounding mild redness, but no definitive evidence of secondary infection. It looked like it needed to be derided. The

presacral wounds looked to be more of a stage II with proud flesh and a central area which had a dressing over it. The note indicated case management would need to arrange for a definitive wound care consultation and arrangements when she returned to her facility.

A document, titled "Adult assessment Intervention," dated 1/28/25 at 6:56 p.m., indicated Resident C had the following wounds:

a. A right inner thigh wound which was described as excoriation. The wound base was reddened, and the wound was present when the resident was admitted to the hospital.

b. A wound on her right flank area (upper back area) which was an evolving Deep Tissue Injury (DTI). It was reddened, opened, and had moist drainage. It was present on admission to the hospital.

c. A wound to her intergluteal cleft which was a stage 3. It was opened, reddened, and had moist drainage. It was present on admission to the hospital.

d. A pressure wound to her left heel, which was an evolving stage III pressure wound. It was open, reddened, and had moist drainage. It was present on admission to the hospital.

e. A pressure wound to her left elbow which was a stage 3 wound. It was open, reddened, and had moist drainage. It was present on admission to the hospital.

A document, titled "Wound/Skin Evaluation," dated 1/29/25 at 3:45 p.m., indicated Resident C had the following wound evaluation:

a. A left heel pressure wound which was an evolving suspected DTI. The wound was 35% black and gray eschar (dead tissue), 60% pink tissue, and 5% epithelial tissue with minimal tan and serosanguineous drainage. The peri-wound tissue was reddened, but blanched. The wound measured 4.5 cm (centimeters) x 3.5 cm x 0.1 cm.

b. A left trochanter (hip) pressure wound which was 50% black and gray eschar and 50% tan and yellow slough (fibrous tissue) with very minimal serosanguineous drainage. The peri-wound had redness, but blanched. The wound measured 3.0 cm x 2.0 cm x 0.1 cm and was staged as unstageable.

	c. A sacral spine pressure wound which was 100% tan and yellow slough with minimal drainage. The peri-wound was reddened and friable, but blanched. The wound measured 6.0 cm x 3.5 cm x 0.1 cm and was staged as unstageable. d. A intergluteal cleft wound caused by friction/MASD (Moisture Associated Skin Disorder), which was 85% pink and red tissue and 15% gray slough tissue and had copious amounts of drainage. The peri-wound was reddened, but blanched. The wound measured 5.0 cm x 2.0 cm x 0.1 cm. and was staged as unstageable. e. A right trochanter (hip) pressure wound which was 100% wet tan slough with copious amounts of drainage. The peri-wound was reddened, but it blanched. The wound measured 4.5 cm x 2.0 cm and was staged as unstageable. f. A right iliac crest pressure wound which was 100% black eschar with minimal drainage. The wound measured 2.5 cm x 1.5 cm and was staged as unstageable. g. A right flank pressure wound which was 80% pink tissue and 20% pink and white tissue with minimal drainage. The peri-wound was reddened, but blanched. The wound measured			

4.5 cm x 3.0 cm x 0.1 cm. and was staged as an evolving suspected DTI.

During an interview, on 2/28/25 at 1:12 p.m., CNA 3 indicated she would bathe, feed, and dress Resident C. She had observed wounds on the resident's right heel, coccyx area, bilateral hips, bilateral elbows, and a bruise on her chest which came and went. She had notified LPN 3, 4 and 5 regarding the wounds. The three nurses applied dressings and cream to her hips and coccyx area. The resident only took sips of liquids and would not open her mouth to eat.

During an interview, on 2/28/25 at 1:30 p.m., LPN 4 indicated she passed medications to Resident C and treated her wounds by placing calmoseptine on her bilateral hips, with a dressing over the wounds. After the wounds opened, she cleaned them with warm water and soap and placed a dry dressing on the wounds. The resident's lower back started to get red. She may have placed the information about the wounds in the doctor's book for the Nurse Practitioner (NP) to see at the next visit. She never specifically phoned the physician or NP for orders for the resident's wounds. She did not know about any other wounds besides the resident's

hip wounds.

During an interview, on 2/28/25 at 1:45 p.m., LPN 5 indicated she gave Resident C her medications daily when she was scheduled to work upstairs. She knew the resident had a bruise on one of her hips. She was not told about any other wounds. If she had known about any wounds, she would have gotten an order to dress the wounds.

During an interview, on 2/28/25 at 1:54 p.m., LPN 6 indicated she gave Resident C her medications, fed her, checked on her, and helped the CNAs transfer her. She knew the resident had a wound to her bilateral hips. She had an abrasion looking area to her lower back. The nurses were covering the wounds with a non-adherent dressing to the weeping wound. LPN 6 had no idea when the dressing needed changed because there was no order for the dressing change. It was changed when it needed changed such as it was leaking. She never called the NP or the physician to notify them of Resident C's wounds or to get an order to treat her wounds. LPN 6 indicated she just tried to treat the "oozing wound." She was never told about any other wounds besides the hip wounds by a CNA.

A current facility policy, titled

	"Skin Integrity Documentation Policy," dated as revised 5/2023 and provided by the Director of Wellness on 2/28/25 at 12:30 p.m., indicated "...Skin Changes 1. The associate/caregiver should report skin changes if noted for residents who are receiving assistance with a bath or shower. 2. The Health and Wellness Director (HWD) or designee should: a. Review the received skin report card from a care associate, take appropriate action and follow the Change of Condition policy...Notify the physician/healthcare provider (HCP) and family of the skin concern as soon as possible. c. Notify the District Director of Clinical Services (DDCS) if a delay in treatment or orders occurs d. Apply dry dressing to wound or pressure injury until physician/HCP orders are received. 3. As indicated, refer wound care needs to Home Health/Hospice for treatment after obtaining physician approval and/or order. Pressure injuries will be staged by a third-party provider, registered nurse or physician/HCP 4. Record the third-party provider's name and their staging of the wound...and update the resident's service plan as indicated. 5. Monitor treatment and progress. Any changes to the wound or lack of improvement should be reported to the physician/Health Care Provider (HCP). 6. Complete a				

	Brookdale Automated Incident Reporting System (BAIRS) Report for Stage 3, 4 or unstageable pressure injury. Document pressure injury under a. nature of incident/miscellaneous/other section and b. type of injury/impairment/open area or other if skin tissue is the result of an incident, injury, fall or is determined unstageable...." This citation relates to Complaint IN00454251.			

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 SIGNATURE	TITLE	(X6) DATE