

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/17/2024	
NAME OF PROVIDER OR SUPPLIER ELMS AT MICHIGAN CITY, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD, MICHIGAN CITY, , 46360					
(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 Complaint IN00447782. Complaint IN00447782 - State deficiencies related to the allegations are cited at R0052 and R0240. Survey date: December 17, 2024 Facility number: 012180 Residential Census: 74 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/26/24.	R 0000					
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient			01/31/2025	

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- (1) sexual abuse;
- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on record review and interview, the facility failed to ensure a resident was free from neglect and adequate supervision was provided to a cognitively impaired resident in the dining room, a thermal burn was immediately reported to a nurse, a burn was immediately assessed by a nurse, appropriate first aid was provided, the burn was covered with a dressing, and treatments were administered in accordance with the physician's orders for 1 of 1 resident reviewed for burns. (Resident B) The deficient practice resulted in the resident spilling hot tea on the right inner thigh and left hip causing second degree burns and burn care was delayed for over 29 hours.

Finding includes:

The closed record for Resident B was reviewed on 12/17/24 at 10:19 a.m. Diagnoses included, but were not limited to, dementia, anxiety, depression, and dysphagia (difficulty

practice;

Educated
team members to follow the
designated care plan for the
affected resident

Educated
Team members on Spilled
Liquid Inservice 04/03/2024

How
will the facility identify other
residents having the potential to
be affected
by the same deficient practice
and what corrective action will
be taken;

Select
Rehab COTA will screen all
Memory Care residents for
adaptive equipment and
self-feeding
capabilities by 01/31/2025

What
measures will be put into place
or what systemic changes the

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swallowing).

The Service Plan, dated 12/21/23, indicated the resident required regular prompting due to confusion and disorientation, employee assistance in managing bowel and/or bladder care, and reminders for meals.

A Progress Note, dated 3/30/24 at 6:45 a.m. and documented as a late entry on 3/31/24 at 6:00 a.m., indicated staff were alerted to a yell in the dining room. Staff found the resident had spilled hot tea in their lap. The resident's pants were wet, and the resident stated it hurt when it happened. The area was wet and warm and no discoloration or pain to touch was noted at that time.

The next documented entry in the Progress Notes was dated 3/31/24 at 6:00 a.m. The entry indicated the Assistant Director of Health and Wellness (ADHW) was alerted by the midnight nurse and aide that the resident had a red "unblanching" area (a skin lesion that doesn't fade when pressure was applied) with fluid filled bubbles on the top of the right inner thigh. A red area and a fluid filled spot was also observed on the left posterior thigh. The resident had no complaints of pain when the areas were touched. The resident's son and hospice were notified. Hospice staff indicated

facility will make to ensure that the deficient practice does not recur;

DHW will utilize a new assessment tool to care for residents who could benefit from adaptive equipment and supervision during snacks and meals.

The Nursing Team will be educated on following designated care plans for all Memory Care residents and following First Aid guidelines on burns. Nursing education will include following physician orders and nursing care plan/assessment requirements.

All Team Members will complete an Inservice on Basic Injury Assessment

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

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the nurse would be in that day to assess the areas.

A Progress Note, dated 3/31/24 at 12:04 p.m., indicated hospice was in the facility to evaluate the right inner thigh and left hip. An order was obtained for Silver Sulfadiazine (SSD) 1% cream (a cream to treat and prevent wound infections in second- and third-degree burns). The cream was to be applied three times a day and the areas were to be left open to air. A second-degree burn, also known as a partial-thickness burn, is an injury that affects the outer layer of skin (epidermis) and part of the underlying layer (dermis). Common causes of second-degree burns include hot liquids (e.g., boiling water, steam) and hot objects. These burns are typically very painful, red, blistered, moist, soft, and blanch when touched. A third-degree burn involves all layers of the skin and sometimes the fat and muscle tissue under the skin. The skin may appear stiff, waxy white, leathery or gray. These types of burns often need skin grafts to close the wound. These burns occur from a flame, hot liquids, or superheated gasses.

into place;
and

Care plans will be updated quarterly on changes in condition.

The Memory Care Director or designee will audit the use of adaptive equipment by nursing staff 3x per week ongoing

By what date the systemic changes will be completed?

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The professional website, <https://my.clevelandclinic.org/health/symptoms/24527-second-degree-burn>, indicated the following:

" ...How do you treat a second-degree burn?

If you have a small second-degree burn (less than 3 inches in diameter), you can treat it at home:

- Use cool water to gently wash your burn. Try to keep your burn area under water for at least five minutes, up to 30 minutes. Gently pat the burn dry with a clean towel.
- Cover your burn with a clean bandage or wound dressing like non-stick gauze.
- Avoid touching your burn or placing clothing on your skin that can cause friction or rub against your wound.
- Take over-the-counter pain relievers (acetaminophen or ibuprofen) as recommended by your provider if you experience pain.
- Change your bandage at least once daily...

A common prescription cream to treat second-degree burns is silver sulfadiazine (Silvadene®). If you have an infected burn, which is a burn that's extremely

painful, swollen and leaks pus, see a healthcare provider. They may prescribe antibiotics to clear the infection from your body...

Should I let my second-degree burn air out?

You should keep your burn covered for the first few days after the event as you let your skin heal. Make sure your blisters stay closed on your skin. If a blister breaks open, you should keep your burn covered with a bandage to prevent an infection. If the blister isn't broken, you can let your burn air out or breathe without a bandage ..."

The Hospice Visit Note, dated 3/31/24, indicated the burn to the right inner thigh measured 1.5 centimeters (cm) x 1 cm with a 1 cm x 14 cm area of "scorched skin" extending toward the knee. The blister was open. The burn to the left hip area was a 9 cm x 9 cm area of "beefy red scorched skin" with a 3 cm x 8 cm fluid filled blister in the center. The information was reported to the on-call hospice physician and orders were received for Silver Sulfadiazine (SSD) 1% cream, apply a quarter size amount to the affected areas of the right inner thigh and the left hip three times a day.

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The April 2024 Treatment Administration Record (TAR) indicated the SSD cream was not administered in accordance with the physician's order for 3 of 12 opportunities between 4/1/24 and 4/4/24.

During an interview on 12/17/24 at 1:45 p.m., RN 1 indicated the resident needed assistance with meals and the resident's ability to feed themselves fluctuated.

During an interview on 12/17/24 at 2:06 p.m., the Health and Wellness Director (HWD) and the Administrator indicated the incident with the hot tea happened on the weekend and there were discrepancies at first as to whether the incident happened on March 30th or 31st. The HWD indicated it was determined the incident happened on 3/30/24.

A facility statement obtained from CNA 1 on 3/31/24, indicated the resident was given hot tea for complaints of a sore throat. No date and time were documented. CNA 1 indicated she left the dining room and went to get the rest of her "list" up for breakfast. When the CNA returned to the dining room, she was told by CNA 2 the resident spilled the hot tea on themselves. When the resident was taken to their bedroom by CNA 1, no redness was noted. During CNA 1's last round of the

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day, the CNA noticed what she thought was a skin tear on the inside of the resident's leg and she reported the area to QMA 1. Documentation in the statement did not indicate the nurse on duty was notified.

A facility statement obtained from CNA 2 on 3/31/24, indicated she was walking past the dining room on 3/30/24 when she heard the resident scream. The resident had spilled hot tea on themselves. The CNA took the tea and dried the resident off, she also put a towel on the resident. CNA 2 indicated she didn't realize the resident had burned themselves because the tea didn't seem to be that hot. Documentation in the statement did not indicate the nurse on duty was notified.

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A facility statement obtained from QMA 1 on 3/31/24, indicated the resident was wheeled into the dining room between 6:15 a.m. and 6:45 a.m. The resident was given a cup of hot tea. The resident began to spill the tea in their lap. A second aide took the mug and gave the resident a cold towel. The QMA indicated the aides did not report any redness to the resident's legs throughout the shift and the resident did not complain of any pain. Documentation in the statement did not indicate the nurse on duty was notified.

The facility investigation, dated 4/2/24, indicated CNA 1 had gotten the resident up for breakfast on 3/30/24. The resident was complaining of a sore throat and asked for hot chocolate. Hot chocolate was not available, and the resident was given a cup of hot tea instead. CNA 2 heard the resident yell out. When she went to the table, she took the tea from the resident and wiped them off and put a towel on them. CNA 2 indicated when she removed the tea, it did not seem that hot. After breakfast, CNA 1 took the resident back to their apartment. CNA 1 did not notice any redness nor was the resident indicating they were hurting. On the last round of the day, CNA 1 noticed what looked like a skin tear on the resident's

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inner leg and she made QMA 1 aware. The ADHW was notified of the incident on 3/31/24 at 6:00 a.m. She proceeded to assess the area and notified hospice.

There was no documentation indicating the resident was supervised in the dining room with a hot beverage, the CNAs or the QMA immediately notified the nurse on duty on 3/30/24 or that a nursing assessment of the affected area was completed.

The investigation follow up indicated staff education was provided on 4/2/24, which included hot beverages would not be served unless the resident was assisted or supervised, any hot beverage spilled on residents should be reported immediately to the nurse and the nurse should immediately assess and continue to evaluate on each shift for 24 hours. All hot liquids were to be cooled before being given to the resident if drinking independently.

Additional investigation documentation, completed by the HWD on 4/5/24, indicated CNA 2 wiped up the hot tea after the resident spilled it and she put a towel on the inside of the resident's pant leg to let them eat breakfast. CNA 2 told CNA 1, and CNA 1 took the

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resident to their room after breakfast and changed them. CNA 2 did not assist with that round. CNA 2 did assist with the round after lunch and noticed an area like a skin tear to the inner right thigh, no other areas of redness were noted. CNA 2 indicated she has not given the resident hot coffee due to the resident being unable to hold it. She also indicated if she had seen CNA 1 give the hot tea to the resident, she would have told her not to do so.

Additional investigation documentation by the HWD on 4/5/24, indicated QMA 2 notified LPN 1 at 10:00 p.m. (no date documented) that the resident had an area to the right inner thigh and left outer thigh. The LPN notified the on-call hospice staff of the wound. The LPN assessed the area and was unaware hot liquid had been spilled on the resident earlier. She thought the wound was from being in bed. The nurse did not feel the resident should have been left alone with a hot liquid.

There was no documentation in the nursing progress notes between 3/30/24 at 6:45 a.m. and 3/31/24 at 6:00 a.m. which indicated the nurse was immediately notified of the skin discoloration and blisters to the right inner thigh and the left outer thigh. There were also no

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further skin assessments documented by facility staff during the same time period.

A Counseling Documentation Form, dated 4/8/24, indicated on 3/30/24 CNA 1 gave a Memory Care resident (who needed full assistance) a hot beverage and left the resident unattended. The Memory Care resident had the inability to hold the beverage which resulted in spilling on the resident causing severe burns to both legs. The resident was not immediately attended to by removing the hot fabric which resulted in the burns being more severe. The CNA's employment with the facility was terminated.

A Counseling Documentation Form, dated 4/8/24, indicated on 3/30/24 QMA 1 failed to give appropriate direction to team members to properly care for a resident who spilled a hot beverage on themselves. In addition, the QMA failed to report the incident to the nurse. Without the nurse present on the Memory Care floor, the QMA did not observe the resident for skin damage during her shift. The QMA received a written warning.

During an interview on 12/17/24 at 3:15 p.m., the HWD indicated CNA 1 had indeed been terminated due to leaving the resident unattended with a hot

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beverage and not immediately removing the resident's clothes. QMA 1 had also received a written warning for failing to report the incident to the nurse. The HWD indicated documentation should have been completed in the nursing progress notes of any additional skin assessments between 3/30/24 and 3/31/24. She also indicated that she was unaware that there was no documentation in the nursing progress notes of when QMA 2 notified LPN 1 of the areas to the right inner thigh and the left outer thigh. Documentation should have been completed by LPN 1. The HWD indicated the resident should not have been left unattended in the dining room, should have had their clothes changed, and the nurse should have been notified immediately.

This citation relates to Complaint IN00447782.

Based on record review and interview, the facility failed to ensure a resident was free from neglect and adequate supervision was provided to a cognitively impaired resident in the dining room, a thermal burn was immediately reported to a nurse, a burn was immediately assessed by a nurse, appropriate first aid was provided, the burn was covered with a dressing, and treatments

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were administered in accordance with the physician's orders for 1 of 1 resident reviewed for burns. (Resident B) The deficient practice resulted in the resident spilling hot tea on the right inner thigh and left hip causing second degree burns and burn care was delayed for over 29 hours.

Finding includes:

The closed record for Resident B was reviewed on 12/17/24 at 10:19 a.m. Diagnoses included, but were not limited to, dementia, anxiety, depression, and dysphagia (difficulty swallowing).

The Service Plan, dated 12/21/23, indicated the resident required regular prompting due to confusion and disorientation, employee assistance in managing bowel and/or bladder care, and reminders for meals.

A Progress Note, dated 3/30/24 at 6:45 a.m. and documented as a late entry on 3/31/24 at 6:00 a.m., indicated staff were alerted to a yell in the dining room. Staff found the resident had spilled hot tea in their lap. The resident's pants were wet, and the resident stated it hurt when it happened. The area was wet and warm and no discoloration or pain to touch was noted at that time.

The next documented entry in

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the Progress Notes was dated 3/31/24 at 6:00 a.m. The entry indicated the Assistant Director of Health and Wellness (ADHW) was alerted by the midnight nurse and aide that the resident had a red "unblanching" area (a skin lesion that doesn't fade when pressure was applied) with fluid filled bubbles on the top of the right inner thigh. A red area and a fluid filled spot was also observed on the left posterior thigh. The resident had no complaints of pain when the areas were touched. The resident's son and hospice were notified. Hospice staff indicated the nurse would be in that day to assess the areas.

A Progress Note, dated 3/31/24 at 12:04 p.m., indicated hospice was in the facility to evaluate the right inner thigh and left hip. An order was obtained for Silver Sulfadiazine (SSD) 1% cream (a cream to treat and prevent wound infections in second- and third-degree burns). The cream was to be applied three times a day and the areas were to be left open to air. A second-degree burn, also known as a partial-thickness burn, is an injury that affects the outer layer of skin (epidermis) and part of the underlying layer (dermis). Common causes of second-degree burns include hot liquids (e.g., boiling water, steam) and hot objects. These burns are typically very painful,

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red, blistered, moist, soft, and blanch when touched. A third-degree burn involves all layers of the skin and sometimes the fat and muscle tissue under the skin. The skin may appear stiff, waxy white, leathery or gray. These types of burns often need skin grafts to close the wound. These burns occur from a flame, hot liquids, or superheated gasses.

The professional website, <https://my.clevelandclinic.org/health/symptoms/24527-second-degree-burn>, indicated the following:

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If you have a small second-degree burn (less than 3 inches in diameter), you can treat it at home:

- Use cool water to gently wash your burn. Try to keep your burn area under water for at least five minutes, up to 30 minutes. Gently pat the burn dry with a clean towel.
- Cover your burn with a clean bandage or wound dressing like non-stick gauze.
- Avoid touching your burn or placing clothing on your skin that can cause friction or rub against your wound.
- Take over-the-counter pain

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relievers (acetaminophen or ibuprofen) as recommended by your provider if you experience pain.

- Change your bandage at least once daily...

A common prescription cream to treat second-degree burns is silver sulfadiazine (Silvadene®). If you have an infected burn, which is a burn that's extremely painful, swollen and leaks pus, see a healthcare provider. They may prescribe antibiotics to clear the infection from your body...

Should I let my second-degree burn air out?

You should keep your burn covered for the first few days after the event as you let your skin heal. Make sure your blisters stay closed on your skin. If a blister breaks open, you should keep your burn covered with a bandage to prevent an infection. If the blister isn't broken, you can let your burn air out or breathe without a bandage ..."

The Hospice Visit Note, dated 3/31/24, indicated the burn to the right inner thigh measured 1.5 centimeters (cm) x 1 cm with a 1 cm x 14 cm area of "scorched skin" extending toward the knee. The blister was open. The burn to the left hip area was a 9 cm x 9 cm area of

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"beefy red scorched skin" with a 3 cm x 8 cm fluid filled blister in the center. The information was reported to the on-call hospice physician and orders were received for Silver Sulfadiazine (SSD) 1% cream, apply a quarter size amount to the affected areas of the right inner thigh and the left hip three times a day.

The April 2024 Treatment Administration Record (TAR) indicated the SSD cream was not administered in accordance with the physician's order for 3 of 12 opportunities between 4/1/24 and 4/4/24.

During an interview on 12/17/24 at 1:45 p.m., RN 1 indicated the resident needed assistance with meals and the resident's ability to feed themselves fluctuated.

During an interview on 12/17/24 at 2:06 p.m., the Health and Wellness Director (HWD) and the Administrator indicated the incident with the hot tea happened on the weekend and there were discrepancies at first as to whether the incident happened on March 30th or 31st. The HWD indicated it was determined the incident happened on 3/30/24.

A facility statement obtained from CNA 1 on 3/31/24, indicated the resident was given hot tea for complaints of a sore

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throat. No date and time were documented. CNA 1 indicated she left the dining room and went to get the rest of her "list" up for breakfast. When the CNA returned to the dining room, she was told by CNA 2 the resident spilled the hot tea on themselves. When the resident was taken to their bedroom by CNA 1, no redness was noted. During CNA 1's last round of the day, the CNA noticed what she thought was a skin tear on the inside of the resident's leg and she reported the area to QMA 1. Documentation in the statement did not indicate the nurse on duty was notified.

A facility statement obtained from CNA 2 on 3/31/24, indicated she was walking past the dining room on 3/30/24 when she heard the resident scream. The resident had spilled hot tea on themselves. The CNA took the tea and dried the resident off, she also put a towel on the resident. CNA 2 indicated she didn't realize the resident had burned themselves because the tea didn't seem to be that hot. Documentation in the statement did not indicate the nurse on duty was notified.

A facility statement obtained from QMA 1 on 3/31/24, indicated the resident was wheeled into the dining room between 6:15 a.m. and 6:45 a.m. The resident was given a

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	cup of hot tea. The resident began to spill the tea in their lap. A second aide took the mug and gave the resident a cold towel. The QMA indicated the aides did not report any redness to the resident's legs throughout the shift and the resident did not complain of any pain. Documentation in the statement did not indicate the nurse on duty was notified.			
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The facility investigation, dated 4/2/24, indicated CNA 1 had gotten the resident up for breakfast on 3/30/24. The resident was complaining of a sore throat and asked for hot chocolate. Hot chocolate was not available, and the resident was given a cup of hot tea instead. CNA 2 heard the resident yell out. When she went to the table, she took the tea from the resident and wiped them off and put a towel on them. CNA 2 indicated when she removed the tea, it did not seem that hot. After breakfast, CNA 1 took the resident back to their apartment. CNA 1 did not notice any redness nor was the resident indicating they were hurting. On the last round of the day, CNA 1 noticed what looked like a skin tear on the resident's inner leg and she made QMA 1 aware. The ADHW was notified of the incident on 3/31/24 at 6:00 a.m. She proceeded to assess the area and notified hospice.

There was no documentation indicating the resident was supervised in the dining room with a hot beverage, the CNAs or the QMA immediately notified the nurse on duty on 3/30/24 or that a nursing assessment of the affected area was completed.

The investigation follow up indicated staff education was

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provided on 4/2/24, which included hot beverages would not be served unless the resident was assisted or supervised, any hot beverage spilled on residents should be reported immediately to the nurse and the nurse should immediately assess and continue to evaluate on each shift for 24 hours. All hot liquids were to be cooled before being given to the resident if drinking independently.

Additional investigation documentation, completed by the HWD on 4/5/24, indicated CNA 2 wiped up the hot tea after the resident spilled it and she put a towel on the inside of the resident's pant leg to let them eat breakfast. CNA 2 told CNA 1, and CNA 1 took the resident to their room after breakfast and changed them. CNA 2 did not assist with that round. CNA 2 did assist with the round after lunch and noticed an area like a skin tear to the inner right thigh, no other areas of redness were noted. CNA 2 indicated she has not given the resident hot coffee due to the resident being unable to hold it. She also indicated if she had seen CNA 1 give the hot tea to the resident, she would have told her not to do so.

Additional investigation documentation by the HWD on 4/5/24, indicated QMA 2 notified

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LPN 1 at 10:00 p.m. (no date documented) that the resident had an area to the right inner thigh and left outer thigh. The LPN notified the on-call hospice staff of the wound. The LPN assessed the area and was unaware hot liquid had been spilled on the resident earlier. She thought the wound was from being in bed. The nurse did not feel the resident should have been left alone with a hot liquid.

There was no documentation in the nursing progress notes between 3/30/24 at 6:45 a.m. and 3/31/24 at 6:00 a.m. which indicated the nurse was immediately notified of the skin discoloration and blisters to the right inner thigh and the left outer thigh. There were also no further skin assessments documented by facility staff during the same time period.

A Counseling Documentation Form, dated 4/8/24, indicated on 3/30/24 CNA 1 gave a Memory Care resident (who needed full assistance) a hot beverage and left the resident unattended. The Memory Care resident had the inability to hold the beverage which resulted in spilling on the resident causing severe burns to both legs. The resident was not immediately attended to by removing the hot fabric which resulted in the burns being more severe. The

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CNA's employment with the facility was terminated.

A Counseling Documentation Form, dated 4/8/24, indicated on 3/30/24 QMA 1 failed to give appropriate direction to team members to properly care for a resident who spilled a hot beverage on themselves. In addition, the QMA failed to report the incident to the nurse. Without the nurse present on the Memory Care floor, the QMA did not observe the resident for skin damage during her shift. The QMA received a written warning.

During an interview on 12/17/24 at 3:15 p.m., the HWD indicated CNA 1 had indeed been terminated due to leaving the resident unattended with a hot beverage and not immediately removing the resident's clothes. QMA 1 had also received a written warning for failing to report the incident to the nurse. The HWD indicated documentation should have been completed in the nursing progress notes of any additional skin assessments between 3/30/24 and 3/31/24. She also indicated that she was unaware that there was no documentation in the nursing progress notes of when QMA 2 notified LPN 1 of the areas to the right inner thigh and the left outer thigh. Documentation should have been completed by

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	LPN 1. The HWD indicated the resident should not have been left unattended in the dining room, should have had their clothes changed, and the nurse should have been notified immediately. This citation relates to Complaint IN00447782.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure antibiotic therapy was initiated in a timely manner for 1 of 3 residents reviewed for non-pressure skin ulcers. (Resident D) Finding includes: The record for Resident D was reviewed on 12/17/24 at 2:45 p.m. Diagnoses included, but were not limited to, type 2 diabetes, peripheral vascular disease, heart disease, and high blood pressure. The resident was admitted to the facility with a left foot diabetic ulcer that was being treated by a home health agency. The home health nurse	R 0240	R240- Health Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; serviced 3rd party At Home Quality of Care in-serviced Mobi-Care NP on coordination of care. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	01/31/2025

would complete the treatments three times a week and the Nurse Practitioner (NP) would visit the resident once weekly to assess the wound and obtain wound measurements.

A Nurse's Note, dated 11/26/24 at 8:30 p.m., indicated the resident's bandage was replaced to the left foot due to excessive foul smelling drainage.

An Assisted Living Open Area Flow Sheet, dated 11/22/24, indicated the current wound treatment was to cleanse the ulcer with normal saline, pat dry, apply Betadine (an antiseptic) solution, gauze sponge, and wrap with kerlix.

An Assisted Living Open Area Flow Sheet, Dated 11/29/24, indicated the treatment was changed to use Dakin's (an antiseptic) solution, apply calcium alginate (a type of dressing) to the wound bed, cover with a gauze sponge, and wrap with kerlix.

A culture of the wound was collected on 12/6/24 by the home health nurse and sent to the lab on 12/7/24. The results of the wound swab was reported to the home health agency on 12/8/24. The pathogens reported in the culture were the following:

Reviewed residents on 3rd party services for any outstanding orders

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

Hold weekly meetings with 3rd party home health companies to coordinate care services provided.

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; and

Inservice Home Health Providers on new 3rd Party Communication form to be completed at each visit

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-25% Pseudomonas aeruginosa

-25% Ralstonia

-25% Enterococcus faecalis

-25% Citrobacter freundii

The antibiotics that would treat the infection were listed on the report.

A Wound NP note, dated 12/10/24, indicated the left foot wound measured 6.39 centimeters (cm) in length by 2.42 cm in width. There was a moderate amount of serous (a clear watery fluid) drainage noted with 91-100% granulation (healing tissue present). A wound culture was pending and there were signs and symptoms of infection.

A Physician's Order, dated 12/17/24, indicated Levofloxacin (an antibiotic) 750 milligrams (mg) every day times 10 days for a wound infection.

During an interview on 12/17/24 at 3:05 p.m., RN 1 indicated the resident was being seen by the home health nurse three times a week to do the wound treatment and the NP came weekly to take measurements and assess the wound or change the treatment. The NP was in the building that day to look at the wound. RN 1 indicated the home health agency faxed the wound culture results to her today (12/17/24)

By
what date the systemic changes
will be completed

01/31/2025

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and she had to call the NP to get orders for treatment. New orders for an antibiotic were obtained 12/17/24.

During an interview on 12/17/24 at 3:20 p.m., the Health and Wellness Director (HWD) indicated she was unaware there was a nine day delay in obtaining orders to treat the infection and would follow up with the home health care agency. She indicated there needed to be better communication between both agencies and the nursing staff.

This citation relates to Complaint IN00447782.

Based on record review and interview, the facility failed to ensure antibiotic therapy was initiated in a timely manner for 1 of 3 residents reviewed for non-pressure skin ulcers. (Resident D)

Finding includes:

The record for Resident D was reviewed on 12/17/24 at 2:45 p.m. Diagnoses included, but were not limited to, type 2 diabetes, peripheral vascular disease, heart disease, and high blood pressure.

The resident was admitted to the facility with a left foot diabetic ulcer that was being treated by a home health agency. The home health nurse

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would complete the treatments three times a week and the Nurse Practitioner (NP) would visit the resident once weekly to assess the wound and obtain wound measurements.

A Nurse's Note, dated 11/26/24 at 8:30 p.m., indicated the resident's bandage was replaced to the left foot due to excessive foul smelling drainage.

An Assisted Living Open Area Flow Sheet, dated 11/22/24, indicated the current wound treatment was to cleanse the ulcer with normal saline, pat dry, apply Betadine (an antiseptic) solution, gauze sponge, and wrap with kerlix.

An Assisted Living Open Area Flow Sheet, Dated 11/29/24, indicated the treatment was changed to use Dakin's (an antiseptic) solution, apply calcium alginate (a type of dressing) to the wound bed, cover with a gauze sponge, and wrap with kerlix.

A culture of the wound was collected on 12/6/24 by the home health nurse and sent to the lab on 12/7/24. The results of the wound swab was reported to the home health agency on 12/8/24. The pathogens reported in the culture were the following:

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-25% *Pseudomonas aeruginosa*

-25% *Ralstonia*

-25% *Enterococcus faecalis*

-25% *Citrobacter freundii*

The antibiotics that would treat the infection were listed on the report.

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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