STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00311140. Complaint IN00311140 - Substantiated. Federal deficiencies related to the allegations are cited at F686. Survey dates: November 18, 19, 20, 21, and 22, 2019 Facility number: 001156 Provider number: 155505 AIM number: 100453350 Census Bed Type: SNF/NF: 43 Total: 43 Census Payor Type: Medicare: 6 Medicaid: 22 Other: 15 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on November 27, 2019.	F 0000	*Brookdale Robin Run has enclosed the Plan of Corrections for the above referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all Statutory and Regulatory Requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal argument nor have we identified all mitigating factors. The facility desires that this Plan of Correction be considered the facility's allegation of compliance.*	
F 0686 SS=K Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent pressure ulcers, complete follow-up assessments, track wound progression, follow interventions, and notify the physician with worsening of wounds up to and including, infections for 5 of 5 residents reviewed for pressure ulcers (Residents B, C, D, E, and F). Resident B's Stage 2 ulcer progressed to an unstageable ulcer with a wound infection and Resident C's stage 3 ulcer worsened to a Stage 4 with signs of infection. The immediate jeopardy began on 10/8/19 when staff failed to complete assessments and notify the physician of a pressure ulcer with symptoms of infection which resulted in the pressure ulcer being a stage 3 when assessed and worsening to a stage 4. The Executive Director (ED) and Regional Director of Clinical Operations (RDCO) were notified of the immediate jeopardy at 3:17 p.m. on 11/20/19. The immediate jeopardy was removed on 11/21/19, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Record review was completed for Resident C on	F 0686	**I. Residents B, C and D no longer reside at the community. The Director of Clinical Services/designee completed skin assessments on Residents E and F on 11-22-19 and documented on the Weekly Skin Integrity Review Form. The Director of Clinical Services/designee completed Braden Scales on Residents E and F on 11-20-19. The Director of Clinical Services/designee completed wound care documentation on the Weekly Wound Data Collection Flow Sheet, family/legal representative and physicians were notified of current status of pressure areas, care plans were updated to address pressure areas and treatments were updated/changed accordingly. II. A skin sweep and Braden Scale were conducted on current residents by the Director of Clinical Services and or designee by 11/22/2019. Physician and family/legal**	12/14/2019

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	11/19/19 at 10:27 a.m. Diagnoses included, but were not limited to metabolic encephalopathy (brain disease that alters brain function), abnormal weight loss, dehydration, disorientation, acute and chronic kidney failure, fracture of left shoulder, contracture to bilateral knees. A quarterly Minimum Data Set (MDS) assessment for Resident C, dated 10/31/19, indicated the resident required extensive assistance of two or more persons for bed mobility and transfers, and extensive assistance of one person for toilet use and personal hygiene. The resident had an unhealed stage 3 (full thickness skin loss involving damage of subcutaneous tissue) pressure ulcer that was not present upon admission to the facility. A care plan, initiated 11/13/15, for Resident C indicated, the resident had a potential for alteration in skin integrity due to impaired mobility, and debility in condition related to diagnosis of fractured left shoulder, osteoarthritis and incontinence. The goal indicated, the resident would have no worsening of skin alteration through review. Interventions included, but were not limited to, apply moisture barrier as needed and as indicated, assist resident with turning and reposition as needed when in bed, evaluate skin condition on a daily and weekly basis, keep skin clean and dry, resident needed heels floated, and the resident needed pressure redistribution/reduction seat cushion. A second care plan indicated, Resident C had a pressure ulcer on the right gluteal fold area. The goal indicated, the resident would have no signs of worsening pressure ulcer through review date. Interventions included, but were not limited to, keep the resident clean and dry as needed and as indicated, provide a pressure-relieving mattress		**representative notifications, wound treatments, and care plans were updated for residents that were identified with wounds. Residents identified at risk as noted on the Braden Scale had interventions implemented. The three residents using a ROHO cushion had a Physical Therapy Assistant check the ROHO cushion on 11/21/2019 to verify they were inflated. III. Director of Clinical Services or designee provided re-education to the licensed nursing associates, regarding the "Change of Condition" (which includes physician and family/legal representative notifications), "Skin Observation and Wound Prevention Protocol", "Wound Observation and Pressure Injury/Ulcer Staging" policies on 11/20/19 and 11/21/19. Licensed nursing associates who were not re-educated on 11/20/2019 or 11/21/2019 will be re-educated prior to working their next shift at the community. The Director of Clinical Services and/or designee will provide re-education to Clinical Associates regarding turning Residents every two hours as per physician orders, and checking ROHO cushions daily to verify the ROHO cushion is**	

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	on bed, provide adequate nutrition and hydration, turn and reposition as needed and as indicated when in bed, and skin assessment weekly on Monday in the electronic medical record. A Progress Note for Resident C, dated 10/8/19 at 10:05 p.m., indicated, dressing to left gluteal fold changed, pressure ulcer was cleaned with normal saline and covered. Ulcer was foul smelling and oozing sanguineous (bloody) drainage, Allevyn (fluid absorbing dressing) used to temporarily cover the wound. There was no documentation the physician had been notified of wound condition. An untitled progress note for Resident C, the Director of Clinical Services (DCS) indicated, was from the wound physician, dated as faxed to the facility on 11/19/19, indicated, on 10/16/19, the resident had a stage 3 wound on the right ischium (lower and back part of the hip bone) measuring 4.5 centimeter (cm) x 3.5 cm x 0.9 cm, with minimal to moderate drainage. The physician documented, there was an uninflated pressure relieving cushion, and resident needed to be in bed. New treatment orders were received, to include, but were not limited to, bed bound until healed, change positions every 2 hours, and occupational therapy to inflate pressure relieving cushion. A physician's order, dated 10/16/19, resident to be bed bound related to stage 3 wound (full thickness skin loss extending into the subcutaneous tissue layer) on right gluteal fold. Resident to be up for meals only and then lay down. Check pressure relieving cushion on wheelchair before getting up and make sure inflated.		**properly inflated. Re-education will be completed by December 14, 2019. Clinical Associates who are not re-educated will be re-educated prior to working their next shift at the Community. The Director of Clinical Services and/or designee will monitor the Weekly Skin Integrity Review Forms on a daily basis by reviewing residents that had a Weekly Skin Integrity Review Form scheduled within the prior 24 hours; if wounds are identified on the Weekly Skin Integrity Review Form, then the Weekly Wound Data Collection Flow Sheet will be reviewed by the Director of Clinical Services/ designee for completeness (physician notification, family notification, treatment, measurements), care plans and Kardex are updated as warranted. The Wound Specialist/designee will conduct rounds once per week in the Community. The Director of Clinical Services and/or designee will conduct weekly rounds with the Wound Specialist/designee, and confirm visit documentation and any physician orders are completed and placed in the medical record.**	

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	A Weekly Wound Data Collection Flow Sheet for Resident C, dated 10/17/19, indicated, information from the wound physician visit on 11/16/19 regarding an in-house acquired wound had been transposed onto the form with no additional information. There was no documentation to indicate a time or date the physician or family were notified. A Weekly Wound Data Collection Flow Sheet for Resident C, dated 10/17/19, indicated, the form had not been filled out. A physician's order, dated 10/19/19, cleanse right gluteal fold wound, pat dry, apply calcium alginate silver micro dressing (highly absorbent dressing to promote healing and formation of granulation tissue) to wound bed, and cover with foam dressing. Change every 3rd day or as needed. A Weekly Skin Assessment forms for Resident B, indicated, random and inconsistent documentation was completed on 10/7/19, 10/14/19, 10/17/19, 10/21/19, 10/24/19, 10/28/19, 10/30/19, 11/6/19, and 11/11/19. An untitled progress note for Resident C, the DCS indicated, was from the wound physician, dated as faxed to the facility on 11/19/19, indicated, on 10/24/19, the resident had a stage 4 wound (can extend into deep tissues like muscle, tendons, ligaments, and bone) on the right ischium (lower and back part of the hip bone) measuring 5.0 cm x 1.5 cm x 2.9 cm, with moderate drainage. The physician documented, there the pressure relieving cushion was still deflated. New treatment orders were received. A physician's order, dated 11/1/19 indicated, admit to hospice due to chronic kidney disease.		**IV. To assist with ongoing compliance, the Director of Clinical Services/designee will review the Skin Integrity Review Forms daily for four (4) weeks, and thereafter will conduct five (5) random audits weekly for eight (8) weeks. The Director of Clinical Services/designee will monitor residents with pressure ulcers and those residents at risk for pressure ulcers as identified by the Braden Scale, for implementation of interventions to reduce pressure ulcer risks/actual pressure ulcers, five (5) random residents will be audited weekly x 4 weeks, and then biweekly x 8 weeks. The Director of Clinical Services/designee will monitor Roho cushions three (3) times weekly for eight (8) weeks. Monitoring will be documented and turned in to Administrator weekly. Results of this monitoring will be reviewed by the Administrator/designee weekly for twelve (12) weeks and at the monthly Quality Assurance Performance Improvement meeting for three (3) months. Director of Clinical Services or designee will present results of this monitoring as well as the education of the licensed nursing associates at the**	

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	A physician's order, dated 11/6/19, bedrest due to wound. A nursing progress note, dated 11/12/19 at 11:25 p.m. indicated, the resident had died with the son at his bedside. During an interview with Wound Physician 13 on 11/22/19 at 10:43 a.m., he indicated, he had been contacted by Resident B's daughter to assess the resident for a wound on his right ischium. On 10/16/19 the resident was assess to have a stage 3 wound. The resident was observed to be sitting up with his Roho (type of redistribution cushion) flatter than a filter, and he was getting no pressure relief in bed. The wound physician gave orders for the resident to be up only for short periods to eat, otherwise to be in bed to terminate pressure. On 10/24/19 the wound had deteriorated to a stage 4 pressure wound, and undermining was observed. The Roho cushion was again observed still not being inflated, he was unsure if staff were not inflating the cushion or if there was a slow leak. This wound was purely pressure based from sitting with no pressure relief. The wound physician indicated, he had not been made aware the resident had passed away. During an interview with the primary care physician on 11/22/19 at 1:32 p.m., he indicated, he wrote several advance care planning notes, and spoke extensively with the family. The primary care physician also indicated, he had personally requested the wound physician and his team be made available for consult on all wounds in the facility, and any recommendations made by the wound physician be considered as orders and written as such. He was not sure why his physician's notes had not been made available		**monthly Quality Assurance Performance Improvement meeting for three (3) months.**	

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	during the survey process as requested, or why the wound assessments had to be faxed over and were not available on the residents' charts. 2. A record review was completed for Resident B on 11/18/19 at 4:20 p.m. Diagnoses included, but were not limited to, bipolar disorder, and drug induced subacute dyskinesia (uncontrolled, involuntary muscle movement). Resident B's care plans, created on 12/11/18, indicated Resident B had potential or actual impairment to skin integrity, and had pressure ulcers on the right heel and left plantar upon admission. There was no documentation the care plans had been revised or new interventions added to reflect the resident's current wound status or needs. A physician's order, dated 4/16/19, indicated weekly skin assessment every Friday. A quarterly Minimum Data Set (MDS) assessment for Resident B, dated 8/30/19, indicated, the resident required extensive assistance of 1 person for bed mobility, toilet use, and personal hygiene. The resident required extensive assistance of two or more persons for transfers. The resident was at risk for pressure ulcers, there was no documentation of unhealed pressure ulcers. A physician's order, dated 9/23/19, indicated a low air loss mattress to maintain skin integrity. A Weekly Wound Data Collection Flow Sheet for Resident B, dated 10/3/19, indicated the resident had a pressure ulcer on the right buttock, first identified as an in-house acquired wound on 10/3/19. The wound was documented as being 2.0 cm x 2.0 cm x 0.2 cm, and a stage 2 (partial			

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	thickness skin loss involving the top layer of skin). A summary indicated, the resident was found with pressure ulcers to bilateral buttocks with surrounding redness. Received new orders for treatment. Roho cushion (pressure relieving cushion used when sitting) was half flat. Educated staff to turn resident often. A Weekly Wound Data Collection Flow Sheet for Resident B, dated 10/3/19, indicated the resident had a pressure ulcer on the left buttock, first identified as an in-house acquired wound on 10/3/19. There was no documentation to indicate a time or date the physician or family were notified. The wound was documented as being 1.0 cm x 1.0 cm x 0.2 cm, and a stage 2. A Progress Note, dated 10/3/19 at 5:27 p.m., indicated the resident had a skin wound or ulcer. The primary care provider recommended dry dressing on right heel, and calmoseptine (protects skin from moisture) on coccyx. A late entry Progress Note for Resident B, dated 10/5/19 at 1:27 p.m., and created by Registered Nurse (RN) 10 on 10/6/2019 at 11:48 p.m., indicated the resident had pressure ulcers to bilateral buttocks and right heel. A late entry Progress Note for Resident B, dated 10/5/19 at 9:27 p.m., and created by RN 7 on 10/6/2019 at 9:56 p.m., indicated the resident was on follow up for a change of condition of skin on bilateral buttocks. The wound had a red area and dark skin. A Weekly Wound Data Collection Flow Sheet for Resident B, dated 10/9/19, indicated the resident had a pressure ulcer, first identified as an in-house acquired wound on 10/3/19, which had resolved.			

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There was no documentation to of the site of the wound, or type.

A Weekly Wound Data Collection Flow Sheet for Resident B, dated 10/9/19, indicated the resident had an in-house acquired pressure ulcer on the coccyx/sacrum, first identified on 10/3/19. The wound was documented as being 6.0 cm x 6.0 cm x 0.2 cm, and a stage 2. A summary indicated, bilateral pressure ulcers had combined and worsened, now included the sacrum and coccyx. Treatment was continued. There was no documentation to indicate a time or date the physician or family were notified.

A Progress Note for Resident B, dated 10/9/19 at 6:27 p.m., indicated the resident's bilateral buttocks pressure ulcer had worsened, it now included the sacrum and coccyx. Treatment as ordered. No documentation of physician notification of change.

A Progress Note for Resident B, dated 10/14/19 at 10:27 p.m., indicated the resident had bilateral ulcers to the buttocks and were not getting better, but worsening, and now included stage 2 (break in the skin extending into deeper layers of the skin). Treatment as ordered. No documentation of physician notification of change.

An untitled progress note for Resident B, the DCS indicated, was from the wound physician, dated as faxed to the facility on 11/19/19. The progress note indicated, on 10/16/19, the resident had a wound on the sacrum measuring 7.4 cm x 3.0 cm x 2.0 cm, with moderate drainage. The patient was directly on the non-healing wound. There was dead tissue to the sacrum. New treatment orders were received.

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	A physician's order, dated 10/16/19, indicated apply Eucerin cream (skin protectant) to bilateral heels and feet topically every day shift for pressure injury. A physician's order, dated 10/18/19, indicated to give Keflex Capsule (antibiotic) 500 milligrams (mg), 1 capsule by mouth two times a day for wound infection until 10/22/2019. A Progress Note for Resident B, dated 10/22/19 at 2:29 a.m., indicated resident continued on antibiotic therapy for infection of open area of buttocks. Treatment as ordered. An untitled progress note for Resident B, the DCS indicated, was from the wound physician, dated as faxed to the facility on 11/19/19. The progress note indicated, on 10/24/19, the resident had a wound on the sacrum measuring 5.5 cm x 4.5 cm x 2.1 cm, with moderate drainage. The patient complained of pain when sitting up. Documentation indicated, patient needed to be off the wound, no sitting up in bed only left to right or flat, and the cushion on chair needed to be inflated. New treatment orders were received. A physician's order, dated 10/24/19, indicated cleanse sacrum area with normal saline, pat dry, and loosely fill calcium alginate (used for debridement of dead or damaged skin) into wound, and cover with foam boarder, 3 times a week on Monday, Wednesday, Friday and as needed. A Progress Note for Resident B, dated 11/5/19 at 9:24 p.m., indicated the physician was made aware of worsening wound condition, and he contacted a wound specialist.			

An untitled progress note for Resident B, the DCS indicated, was from the wound physician, dated as faxed to the facility on 11/19/19. The progress note indicated, on 11/6/19, the resident had a wound on the sacrum measuring 9.7 cm x 9.5 cm x 1.2 cm, with moderate drainage, and friction/sheer. Documentation indicated, there was no pressure relief, the patient was on the wound with a pillow under the wound. The note indicated sliding to the right during transfers, and on-going damage to the left side of wound, with friction/shear to the right. New treatment orders indicated, no pillow under wound, the resident cannot be slid to the right, and this was creating on-going trauma/friction and shearing to left side.

A physician's order, dated 11/6/19, indicated the resident cannot be slid to each side, resident needed to be lifted, due to sliding causing continued trauma to the resident. "...Make sure resident is rolled completely, rolled on each hip only, besides sitting up 90 degree every shift."

A physician's order, dated 11/6/19, indicated apply skin prep wipes (protective film to help reduce friction) to bilateral heels topically two times a day for treatment.

A Progress Note for Resident B, dated 11/15/19 at 10:10 p.m., indicated, the resident was found deceased in a sitting position in bed.

During an interview on 11/22/19 at 10:33 a.m., Wound Physician 13 indicated, he had been contacted to visit Resident B on 10/16/19 due to a new wound on the sacrum. He could not say the resident's wound was unavoidable without further information. He saw the resident again on 10/24/19 and the resident's wound had worsened with undermining in several areas. The wound

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	physician spoke with staff at that time about care as he had previously given instructions for off-loading pressure to her wound, and when he entered to visit, the resident was found lying on her back causing direct pressure to her sacral area. On 11/6/19 the wound had again worsened, was more black, and he found staff had been sliding the resident to the side causing friction/shearing to the same area. Staff were again educated by the wound physician and instructions given to roll the resident, not to slide. The wound physician indicated, original copies of his wound reports to include description of the wound, site, measurements, and new orders were always left in the facility with each visit, he was not sure why Resident B's reports could not be found in the facility. The wound physician indicated, he had not been made aware the resident had passed away. 3. During a random observation of Resident D on 11/18/19 at 1:40 p.m., the resident was sitting in her wheelchair at bedside with blue foam heel protectors on both heels. Bandages to bilateral feet were dated 11/15/19. During a random observation of Resident D on 11/19/19 at 9:22 a.m., the resident was observed lying on her right side in bed, eyes open, heels and sides of her feet in direct contact with the bed, and blue foam heel protectors were on the couch in her room. During an observation of Resident D on 11/19/19 at 9:33 a.m., with Certified Nursing Assistant (CNA) 4, the resident was lying on her right side in the bed, ankle socks on both feet, heels and sides of her feet in direct contact with the bed, no foam heel protectors, and 4 bandages on her feet dated 11/18/19. CNA 4 indicated, the resident			

wore the blue foam heel protectors when she was out of bed in her wheelchair.

During an observation of Resident D on 11/19/19 at 10:05 a.m., the resident was lying on her right side in bed, eyes closed. Her heels and the sides of her feet were in direct contact with the bed, and blue foam heel protectors on the couch in her room.

During an observation of Resident D on 11/22/19 at 10:55 a.m., RN 5 indicated, during the skin sweep the previous evening, the resident was found to have 3 additional wounds the staff had not been aware of.

During an observation of Resident D with Wound Physician 14 and RN 5 on 11/22/19 at 11:06 a.m. Resident D was observed to flinch when the dressings were removed from her feet and her feet were examined. The Wound Physician Assistant indicated, on 10/24/19 Resident D had 4 wounds on her feet. During this observation the resident had 6 wounds documented on her right foot, 3 wounds on her left foot, and 2 wounds on her buttocks. Wound measurements included:
a. right heel 2.0 cm x 0.9 cm with minimal drainage,
b. right anterior foot 5.2 cm x 2.4 cm with minimal drainage,
c. right anterior foot 1.3 cm x 1.3 cm with minimal drainage,
d. left 2nd toe 0.2 cm x 0.4 cm,
e. right 1st toe 0.6 cm x 0.4 cm,
f. under the right 1st toe 0.8 cm x 0.7 cm,
g. posterior right heel 1.8 cm x 1.0 cm with minimal drainage,
h. dorsal (upper side or back) left foot 1.8 cm x 1.2 cm with minimal yellow drainage,
i. left toe 3.5 cm x 2.7 cm with minimal drainage,
j. buttock 1.2 cm x 1.1 cm x <0.1 cm with minimal

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drainage,
k. buttock 0.3 cm x 0.1 cm x <0.1 cm with minimal drainage.

Wound Physician 14 indicated, the right and left heels were healed, as the eschar on both heels could have been peeled off. The remaining wounds were getting larger, and could improve with proper care, and the wounds could possibly have been prevented if staff could have kept Resident D from rubbing her feet together.

During an observation of Resident D with Wound Physician 14 and RN 5 on 11/22/19 at 11:22 a.m., RN 5 indicated, the resident had 2 additional wounds found that morning to include, a deep red discolored area on her right outer calf, visualized as approximately 5.0 cm x 7.0 cm, from rubbing against the wheel chair leg rest, and a 1.0 cm circular stage 2 open area on the top of right lower leg from the strap of the blue pressure booties, these wounds were not documented.

Record review was completed for Resident D on Record review completed on 11/18/19 at 1:45 p.m. Diagnoses included, but were not limited to, fracture of left femur, dementia without behavioral disturbance, and anxiety disorder.

A quarterly MDS for Resident D, dated 10/21/19, indicated, the resident required extensive assistance of one person for transfers, bed mobility, eating, toileting, and personal hygiene. The resident had 6 stage 2 pressure ulcers that were not present upon admission, and 1 venous or arterial ulcer present.

Resident D's care plans indicated, care plans were created on 8/28/18 and 9/12/18 for potential or actual impairment to skin integrity, and having

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	pressure ulcers on the heels and feet. There was no documentation the care plans had been revised or new interventions added to reflect the resident wound status or needs. A Physician's orders for Resident D indicated, the resident had orders to include, 9/12/18 provide heels off or float heels device while in bed and or in wheelchair at all times for wound healing, 10/3/18 weekly skin inspection every Monday, and 10/4/19 resident was to have blue foam heel protectors on when in bed, to maintain skin integrity every shift for wound healing. New wound orders were received on 10/24/19 for her legs, feet, and toes. An order was obtained 11/6/19 for cleansing of a wound without a specified wound site. A Progress Notes for Resident D, dated 9/22/19 - 11/18/19, indicated there was no documentation to indicate the resident was being provided routine nursing preventative wound care interventions, or the physician and family representative were being kept apprised of wound status. An untitled progress note for Resident D, the DCS indicated, was from the wound physician, dated as faxed to the facility on 11/19/19. The progress note indicated on 11/24/19 the resident was seen regarding "trauma" wounds on her left great toe, 2 areas on the right anterior foot, and the right heel. A Weekly Wound Data Collection Flow Sheet for Resident D, dated 10/9/19 - 10/26/19 indicated, there was random and inconsistent documentation regarding multiple in-house acquired ulcers to the resident's toes and feet. There was no documentation to indicate the physician and family representative were consistently being notified of the wounds.			

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	A Weekly Wound Data Collection Flow Sheet for Resident D, dated 11/4/19 indicated, the resident had a pressure ulcer to the sacrum, measuring 7.0 cm x 6.0 cm x 0.1 cm unstageable (full thickness skin loss in which the depth is obscured by dead tissue), with slough (dead tissue) noted to the center of the wound bed. A Weekly Wound Data Collection Flow Sheet for Resident D, dated 11/11/19 indicated, the resident had a pressure ulcer to the sacrum, there was no measurements or description of the wound to indicate progress toward healing or worsening of the wound. A Weekly Skin Assessment forms for Resident D, indicated, random and inconsistent documentation were completed on 10/7/19, 10/9/19, 10/14/19, 10/21/19, 10/28/19, 11/4/19, 11/11/19, and 11/18/19. During an interview with the DCS on 11/20/19 at 10:35 a.m., she indicated, she was unaware of what happened to Resident D's toes as that documentation started in July of 2019. The resident was to have her blue protection booties on at all times. The aides were responsible for assuring the resident had her blue protection booties on, with the nurses were responsible for monitoring compliance. During an interview with the DCS on 11/20/19 at 12:03 p.m., she indicated, Resident D had a newer in-house acquired open area on her sacrum that had been measured, but was not documented on her tracking forms. The DCS could not find documentation to indicate the physician or family had been notified.			

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During an interview with the wound physician on 11/22/19 at 10:22 a.m., he indicated, he had first documented Resident D as having trauma to the tops of her toes as a result of rubbing, he was not sure if that was on her shoes or possibly her chair. The right medial toe was also pressure as it was pressing against another toe. On his last visit 10/24/19 he documented Resident D's wounds as getting better and still believed her shoes were causing superficial wound damage, he wondered if they could have changed the resident's shoes to avoid the wounds.

During an interview with the ADM on 11/22/19 at 11:58 a.m., he indicated, he was not sure if therapy had been involved in wound prevention for Resident D, such as positioning concerns.

4. During a random observation on 11/19/19 at 9:26 a.m., Resident E was observed lying in bed on his left side, and eyes opened. The resident nodded his head when spoken to but did not respond verbally.

During an observation of Resident E's dressing to the left lower buttock, on 11/19/19 at 9:39 a.m., with RN 7. The RN indicated, she did not routinely work with the resident, was unsure of how often the resident's dressing was to be changed, but would check the order. Resident E indicated, the nurses changed his dressings every day, they were good about that.

During an observation of Resident E's wound on 11/22/19 at 11:37 a.m., the resident was observed to flinch when the dressing was being removed and the area around the wound palpated. RN 12 indicated, last week there was slough from the wound, today the wound was clean with no drainage. The wound could have been caused by

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	a cyst under the skin but she was unsure. Record review was completed for Resident E on 11/18/19 at 2:15 p.m. Diagnoses included, but were not limited to, cerebral infarction, muscle weakness, and major depressive disorder. An annual MDS for Resident E, dated 9/10/19, indicated the resident required extensive assistance of one person for bed mobility, and extensive assistance of two or more persons for transfers, toilet use, and person hygiene. The resident was at risk for developing pressure ulcers, no documentation of unhealed pressure ulcers at the time of the assessment. Resident E's care plans indicated, there was a care plan initiated 10/9/18 regarding potential for impairment to skin integrity. A care plan initiated 11/9/19 indicated the resident had a reddened area to the left buttock related to a recent biopsy, with an intervention for observing the resident for healing of the area on the right buttock. Any new or worsening symptoms should have been reported to the physician. A Physician's orders for Resident E indicated, the resident had current orders to include, 10/22/18 weekly skin check on Friday, and 11/9/19 cleanse wound to left buttock with normal saline and apply hydrogel and Allevyn dressing every 3 days for wound healing until healed. A Progress Note for Resident E, dated 11/9/19, indicated, the resident had a skin wound or ulcer. The primary physician had been notified with new orders to apply hydrogel and allevyn dressing every 3 days. A Weekly Skin Integrity Review form for Resident			

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	E, dated 11/8/19, indicated red area to left buttock where resident has a biopsy done. No measurements were documented. Resident E's medical record indicated there was not Weekly Wound Data Collection Flow Sheet completed for the in-house acquired pressure ulcer. During an interview with the DCS on 11/20/19 at 10:39 a.m., she indicated, Resident E was tall, talkative, and would tell staff when he wanted to lay down, therefore she was surprised he had a pressure ulcer. The current area on Resident E's bottom was a newly acquired in-house pressure area, it was not from the previous left biopsy site. During an interview on 11/22/19 at 10:55 a.m., Wound Physician 13 indicated, he was not aware Resident E had a wound on his bottom, he had not been asked to assess the resident. During an interview on 11/22/19 at 1:27 p.m., the primary care physician indicated, he was not aware Resident E had a wound on his bottom, the nursing staff may have asked the wound physician to follow Resident E's wound. 5. During a random observation on 11/19/19 at 9:29 a.m., Resident F was observed sitting up in bed, laptop on his over the bed table in front of him, talking on his cell phone. A low air loss mattress was observed on the bed. During an observation on 11/19/19 at 9:55 a.m., Resident F was observed sitting up in the bed working on his laptop. The resident indicated, he had a history of pressure sores, and had developed the latest pressure sore on his bottom while staying in the facility. The facility had			

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	provided him with a specialty mattress, and the nurses changed his dressing every 3rd day. During an observation on 11/22/19 at 9:50 a.m., Resident F was sitting up in bed working on a laptop. The resident indicated, he had a history of breakdown on his bottom since being in the wheel chair the past 2 years and was he was not good at pressure relief as that involved push-ups in the wheel chair and they were hard. During an observation with RN 12 on 11/22/19 at 11:42 a.m., Resident F was observed to have three small areas of scabbing on his sacral area, there was no drainage or slough. Resident F indicated, he did not get turned at night, he was not sure if that was his fault as he didn't ask, and he was on a specialty mattress. Record review was completed for Resident F on 11/18/19 at 4:00 p.m. Diagnoses included, but were not limit to, paralysis, malignant neoplasm of the prostate, and neuromuscular dysfunction of the bladder. A quarterly MDS for Resident F, dated 10/24/19, indicated, the resident required extensive assistance of one person for bed mobility, toilet use, and personal hygiene. Extensive assistance of two persons for transfers. Resident was at risk for development of pressure ulcers, no documentation to indicate a pressure ulcer at the time of the assessment. Resident F's care plans indicated, on 7/22/19, the resident was care planned for potential/actual impairment to skin integrity. Interventions included evaluate skin condition on a daily and weekly basis.			

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A Progress Note for Resident F, dated 9/20/19 at 2:01 p.m., indicated skin wound or ulcer. Primary care provider recommended new orders to cleanse area with normal saline, pat dry and apply foam dressing every 3 days. There was no documentation to describe the wound, or to indicate the family had been notified.

A Progress Note for Resident F, dated 9/21/19 at 2:00 p.m., indicated the resident remained on follow up for new pressure area to mid lower back.

A Progress Note for Resident F, dated 9/22/19 at 1:56 p.m., indicated the resident with shearing no pressure injury to lower mid back. A subsequent Progress Note on 9/23/19 at 9:05 p.m., indicated, resident was on follow up for a new pressure area to the mid lower back.

A Weekly Wound Data Collection Flow Sheet for Resident F, dated 10/4/19, indicated, the resident had moisture associated skin damage (MASD) on the coccyx, first identified as an in-house acquired on 8/23/19, and reported to the physician and family on 9/25/19. The wound was documented as being 6.0 cm x 3.8 cm x 0.2 cm. A summary indicated, during assessment the resident was identified as having MASD surrounding friction site. Orders were received for a low air loss mattress, and to be up in the chair only 2 hours at a time.

A Weekly Wound Data Collection Flow Sheet for Resident F, dated 10/4/19, indicated, the resident had an area of friction to the lower thoracic spine, first identified as an in-house acquired on 9/21/19, and reported to the physician on 9/25/19. The wound was documented as being 0.3 cm x 0.3 cm x 0.1 cm.

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	A Weekly Wound Data Collection Flow Sheet for Resident F, dated 10/9/19, indicated the resident had a MASD/friction on the coccyx, first identified as an in-house acquired on 8/23/19, and reported to the physician and family on 9/25/19. The wound was documented as being 5.0 cm x 3.0 cm x 0.2 cm. A Weekly Skin Assessment forms for Resident F, indicated incomplete documents were completed on 10/1/19 and 10/15/19. There were no documentation to indicated, additional weekly skin assessments had been completed. A Weekly Wound Data Collection Flow Sheet for Resident F, dated 10/19/19, indicated the resident had a friction wound on the coccyx, first identified as an in-house acquired on 8/23/19, and reported to the physician and family on 9/25/19. The wound was documented as being 1.2 cm x 1.5 cm x 0.2 cm. There were no further Weekly Wound Data Collection Flow Sheets in the resident record regarding this wound. Physician order, dated 10/19/19, indicated cleanse right buttock wound with normal saline, pat dry, and apply a foam dressing every third day and as needed for wound healing. Physician order, dated 11/4/19, indicated low air loss mattress to maintain skin integrity, and resident to be up in wheel chair only 2 hours at a time.A Weekly Wound Data Collection Flow Sheet for Resident F, dated 11/9/19, indicated, the resident had a pressure ulcer on the right buttock, first			

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	identified as an in-house acquired wound on 9/21/19. The wound was documented as being 3.0 cm x 1.0 cm x 0 cm. A Weekly Wound Data Collection Flow Sheet for Resident F, dated 11/16/19, indicated the resident had a pressure ulcer on the right buttock, first identified as an in-house acquired on 9/21/19, and reported to the physician and family on 9/21/19. The wound was documented as being 3.0 cm x 1.2 cm x 0 cm. A Progress Note for Resident F, dated 11/18/19 at 3:16 p.m., indicated cleanse the right buttock wound with normal saline, pat dry, and apply foam dressing, change every 3 days for wound healing. During an interview with the DSC on 11/20/19 at 10:42 a.m., she indicated, Resident F had a motorized wheel chair and was up a lot. He liked to stay up late in the evening, was frequently out of the facility with friends, and would go see his physician which was an hour ride away. The resident's wound was improving, and he was due to be measured again on 11/22/19. During an interview on 11/22/19 at 10:51 a.m., Wound Physician 13 indicated, he had not been asked to assess Resident F's wound. During an interview on 11/19/19 at 12:01 p.m., the DCS indicated, there was no current wound team, wound book for tracking, or wound nurse. Floor nurses on the floor were to complete treatments and			

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	do wound assessments to include measurements. There was a wound physician who visited every two weeks, or more often if needed. The Wound physician and their team assured the DCS they were completing wound measurements, but those reports were not currently available in the facility. If a wound was found in the facility the process would be to do a wound assessment, measure, reach out to medical director and wound doctor and to get an order. Staff were to notify family and the DCS, and document in the progress note and on the summary section of the wound assessment. Upon hire the DCS was handed a handwritten page of wounds, and was told there was no current Nutrition Risk team as there was no dietary manager. DCS hired a wound nurse who worked two days and left. The DCS tracked the wounds on handwritten notes, did the measurements, and documented. Upon asking her corporate support person, was told there was no way to print off a wound spread sheet for tracking purposes. DCS was making the changes and corrections to the process that she was allowed to make to get it back on track. The Administrator (ADM) was aware of the lack of documentation for wound tracking. During an interview on 11/19/19 at 12:20 p.m., Unit Manager (UM) 5 indicated she had only worked in			

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	the facility for two weeks, and had found that nurses on the floor were documenting treatments as completed, but when dressings were checked, found the treatments had not been changed with a new date. When these discrepancies were found the UM and DCS would change the dressings. During an interview on 11/19/19 at 12:32 p.m., Licensed Practical Nurse (LPN) 6 indicated, she was not part of the wound team. The nurses when discovered a wound, would open a change of condition report, called the physician and family, cleaned the wound, followed physician orders, completed wound treatments, also helped with prevention of the wounds. Weekly skin checks on all residents on different days and shifts. Wound assessments used to be done every Tuesday by the previous DCS. There was a wound nurse hired, she was not sure what day she was in the facility. Floor nurses were responsible for completing wound treatments according to orders every shift, or every daily or every 3 days according to orders. When dressings were changed, nurses could tell it had been changed by appearance of the dressing, if clean dry and intact, and they were dated. During an interview on 11/20/19 at 1:38 p.m., the ADM indicated, the facility did not currently have a wound nurse or a wound team, the process was the responsibility of the DCS.			

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	The ADM had been made aware of concerns with assessments and lack of documentation of the wound, and for the past few weeks had been reviewing resident records. He had found confirmation of the issues with the documentation, and the process for obtaining orders. The DCS had been doing a lot of the wound documentation on paper as she was not familiar with the electronic documentation system. The DCS had been overseeing and leading the process in improving the process, and documentation with the nursing line staff. The facility no longer had a wound nurse after the previous one had left. The MDS coordinator was responsible for updating the care plans. Since identification of the issues with the wound program, he was not sure if in-service education had been provided to the nurses. During an interview on 11/20/19 at 2:25 p.m., the Regional Director of Clinical Operations (RDCO) indicated the facility followed the National Pressure Ulcer Advisory Board guidelines on wounds. If the wound was not improving in 3 weeks, the treatment needed to be changed. On 11/19/19 at 2:20 p.m., the DCS provided a policy, titled, "Wound Observation and Pressure Injury/Ulcer Staging Policy", revised 9/2017, and indicated, " ...All licensed nurses should follow established guidelines and protocols to observe,			

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ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	describe tissue, evaluate, measure wounds and stage of pressure injuries/ulcers ...E. All pressure injuries/ulcers will be measured weekly by the Director of Clinical Services or Licensed designee. F. Document all wounds and wound measurements on the Wound Evaluation Flow Sheet. Pressure injury data will also entered on the Weekly Pressure Injury/Ulcer Summary and the medical record. G. Notify the health care provider of any changes, progress or alternative interventions to promote healing ..."On 11/20/19 at 2:25 p.m., the Regional Director of Clinical Operations (RDCO) provided a policy, titled, "Change of Condition for Skilled Nursing Communities", revised 9/2019. The policy indicated, "When a resident is evaluated or assessed as having a change in condition, the charge nurse will follow through in documenting notification to family/legal representative, the health care provider and other licensed nurses in order to facilitate the appropriate plan of care. A. All associates shall communicate any information about a resident's status change to appropriate licensed personnel upon observation ...B. Perform a comprehensive evaluation or assessment consulting the Care Paths as indicated ...document the current situation, background, assessment (RN) or appearance (LPN/LVN) and requests for			

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	the Health Care Provider on the eInteract Change of Condition Evaluation form ...Call the appropriate Health Care Provider to communicate eInteract Change of Condition Evaluation information and any needed treatment orders. Document the change of condition, the Health Care Provider recommendations or new orders, the family/responsible person who was notified with their response, and the nursing interventions implemented with responses to treatment in the Nurse Progress Note ....A resident Change in Condition may include but is not limited to ...skin/wound/ulcer ...The change of condition will be noted on the Care Plan until it is resolved ..."The immediate jeopardy that began on 11/21/19 was removed on 11/22/19 when the facility assessed all residents for risk of pressure ulcer development, and if at risk, interventions were implemented. Residents with current pressure ulcers were reviewed for appropriate care and treatment, and care plans updated. Physician and families were notified of wounds as needed. Nursing staff were in-serviced on pressure ulcer care. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoringThis Federal tag relates to			

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	Complaint IN00311140.3.1-40(a)(1)3.1-40(a)(2)3.1-40(a)(3)			