STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00452731. Complaint IN00452731 - Federal/state deficiencies related to the allegations are cited at F0684. Survey dates: February 6 and 7, 2025 Facility number: 000131 Provider number: 155226 AIM number: 100274910 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 5 Medicaid: 51 Other: 12 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 12, 2025.	F 0000	This provider respectfully requests a desk review in lieu of a post survey review on or after February 7th 2025. Please feel free to contact Roland Mann (Executive Director) if you need any additional information to support the desk review. Thank you for your consideration.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to timely identify and obtain physician's orders for a surgical wound that was present upon admission to the facility for 1 of 4 residents reviewed for wounds (Resident B).	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B's surgical wound	02/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roland Mann	Executive Director	02/22/2025

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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	Findings include: The clinical record for resident B was reviewed on 2/6/25 at 11:30 a.m. The diagnoses included, but were not limited to, anal abscess (swollen area within body tissue, containing an accumulation of pus) and colostomy (colon was diverted to an artificial opening in the abdominal wall). She was admitted to the facility on 1/13/25. An admission assessment, dated 1/13/25 at 8:04 p.m., indicated she had a wound on her right buttock which was 28 centimeters (cm) in length and 13 cm in width. The depth of the wound was eight cm. There were no other wounds identified on the admission assessment. A Nursing Progress Note, dated 1/13/25 at 9:54 p.m., indicated "...This writer notified [name of hospital that discharged resident] ... regarding treatment orders for resident ...unable to find treatment orders but will reach out day shift and wound care regarding orders and have the orders faxed to facility [sic]." A Nursing Progress Note, dated 1/13/25 at 12:36 a.m., indicated the right buttock wound dressing was done with minimal drainage observed. An ostomy (surgically created opening) dressing was done. A care plan, initiated 1/14/25, indicated she was at risk for skin breakdown or further skin breakdown due to current skin impairment and impaired mobility. The goal was for her to be free from further skin breakdown. The interventions included, but were not limited to, preventive treatments as ordered, supplements as ordered, turn and reposition at least every two hours, and		orders have been reviewed and are now in place. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who have wounds and receive/have physician orders upon admission have the potential to be affected by the alleged deficient practice. An audit will be completed to identify any orders for wounds that are not in place on new admissions. An in-service will be completed addressing the deficiency to include new admission skin assessments and new admission physician orders. - **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** An in-service will be completed addressing the deficiency to include new admission skin assessments and new admission physician orders. The facility will ensure that a member of clinical administration will assess all new admits ensuring all wounds are identified, and orders are being followed. Charge nurse to assess on weekends.	

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	provide assistance as needed. A physician's order, dated 1/14/25, indicated to change colostomy bag daily. A physician's order, dated 1/14/25, indicated to provide ostomy care every shift and as needed. Assess the stoma (opening in the abdomen which is used to remove body waste, such as feces and urine, into a collection bag) site every shift for redness, drainage, swelling, warmth and skin integrity. A Nursing Progress Note, dated 1/14/25 at 2:57 p.m., indicated Resident B had an ostomy with a dehisced (separation or opening of a previously closed wound) wound on her abdomen. The clinical record did not contain a treatment order for the right buttock wound or the dehisced abdominal wound on Resident B's abdomen upon admission to the facility. A physician's order, dated 1/15/25, indicated to cleanse the buttock wound, pat dry, and lightly pack the wound with a quarter (1/4) strength Dakin's (antiseptic solution) soaked rolled gauze, cover with ABD (type of dressing), and secure with tape twice daily. A Nursing Progress Note, dated 1/15/25 at 11:02 p.m., indicated the abdominal assessment of an ileostomy (small intestine was diverted to an artificial opening in the abdominal wall) and colostomy. She had two ostomy bags. There was no redness or swelling observed in the area. An Interdisciplinary Team (IDT) Note, dated 1/16/25 at 1:45 p.m., indicated Resident B had a skin injury wound on her right buttock and right		The facility will utilize an audit tool to track all new admission orders and wounds. Audit will be reviewed daily during clinical start-up/rounds **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 ensure compliance the DNS/Designee will complete a physician's orders/wound identification CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	thigh. She was admitted to the facility with a diagnosis of anal abscess and type 2 diabetes and had surgical debridement (removal of damaged tissue). The treatment used for the wound was Dakin's solution. A Nursing Progress Note, dated 1/18/25 at 6:22 a.m., indicated the abdominal assessment of an ileostomy and colostomy. The stoma was pink. A Nursing Progress Note, dated 1/19/25 at 10:20 a.m., indicated Resident B's vital signs were within normal limits. She had no complaints about pain or discomfort. The Assistant Director of Nursing had contacted the facility to follow up on Resident B's surgical site related to possible worsened dehiscing due to surgery. Missing staples were observed at the mid abdominal area. Colostomy care was done, and colostomy bag was changed. A dressing was applied to the abdominal area, which was red and painful during treatment. The Nurse Practitioner was notified, and Resident B was sent to hospital. The Hospital- ER (Emergency Room) transfer form, dated 1/19/25, indicated the condition requiring an ER visit was a dehisced incision. The skin condition described at the time of transfer was missing staples. An Acute Care Hospital Colon Rectal Surgery Consult note, dated 1/20/25, indicated Resident B presented with a midline wound separation as well as newly diagnosed pneumonia. She had been having drainage into her wound and separation of the midline wound with surrounding redness and pain. The physical exam showed the abdomen as soft, with dehiscence of the inferior aspect of midline wound. The superior staples were intact. The colostomy was functioning and has			

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	surrounding erythema (redness). Resident B was re-admitted to the facility on 1/23/25. An Admission Minimum Data Set (MDS) assessment, completed 1/29/25, indicated Resident B was cognitively intact and dependent on toileting. During an interview on 2/6/25 at 2:15 p.m., Resident B indicated she had staples on her stomach when she first came to the facility. She had noticed some drainage from the staples before she went back to the hospital. She had told one of the nurses about the drainage. She was unsure how or when the staples were removed, she thought they just fell out. During an interview on 2/7/25 at 1:20 p.m., the Corporate Nurse Consultant (CNC) indicated when Resident B was admitted to the facility, on 1/13/25, there were two ostomy bags present on her abdomen. The discharge hospital had not sent any treatment orders with the discharge packet. Initially, the admitting nurse thought she had two ostomies. The Assistant Director of Nursing Services (ADNS) reached out to the discharging hospital, on 1/13/25, to obtain treatment orders for her wounds. A treatment order for her right buttock and thigh was obtained on 1/15/25. Treatment orders for Resident B's wounds should have been obtained upon admission. There was no physician's order present for the use of two ostomy bags. During an interview on 2/7/25 at 1:40 p.m., Licensed Practical Nurse (LPN) 2 indicated she had changed Resident B's colostomy bag. There were two ostomy bags present on Resident B's			

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	abdomen; one was covering her colostomy, and one bag was over the open, dehisced wound. LPN 2 had notified the former Director of Nursing. During an interview on 2/7/25 at 1:58 p.m., the ADNS indicated when Resident B was admitted to the facility, on 1/13/25, the nurses had assumed that the colostomy and wound adjacent to it were all part of the same area. Resident B had been sent to the facility with two ostomy bags present on the abdomen and both bags had stool in them. The staples on Resident B's abdomen had been covered with the adhesive wafer of the ostomy bag. On 1/19/25, the ADNS was contacted by the nurse on duty around 4:00 a.m. or 5:00 a.m. The nurse on duty was concerned Resident B's surgical wound was coming open. The ADNS was unsure why the nurse on duty had called her instead of the physician when she noticed a change in the wound. The ADNS had called the facility later in the morning, on 1/19/25, and had the staff check the wound. The physician had been notified of the change in appearance of the wound and Resident B had been sent to the acute care hospital for an evaluation. On 2/7/25 at 1:20 p.m., the CNC provided the Nursing Admission/Return Admission Policy and Procedure, last reviewed July 2024, which read "... to provide baseline and accurate documentation of the mental and physical condition of each resident admitted or readmitted to the facility... Admission procedures will be followed for all new admissions including respite care...Initial nursing assessment: Admission Observation...5. A thorough head to toe assessment [including skin] must be done at admission. Any alterations in skin integrity must be identified on nursing assessment. The physician must be notified for specific treatment orders..."			

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	On 2/7/25 at 1:20 p.m., the CNC provided the Skin Management Program, last reviewed May 2022, which read "...Procedure For Alteration In Skin Integrity- Pressure and Non-Pressure...1. Alterations in skin integrity will be reported to the MD/NP [sic], the resident and/or resident representative as well as to the direct care staff. 2. Treatment order will be obtained from the MD/NP [sic]..." This citation relates to Complaint IN00452731. 3.1-37(a)			