STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155176	A. BUILDING 00 B. WING	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00438838. Complaint IN00438838 - Federal/State deficiencies related to the allegations are cited at F686. Survey dates: July 29 and 30, 2024 Facility number: 000092 Provider number: 155176 AIM number: 100266090 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 1 Medicaid: 42 Other: 5 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review complted August 1, 2024	F 0000		
F 0686 SS=G 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 professional standards of practice, to prevent pressure ulcers and does not develop			

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

Jamie Solomon | ED | 09/03/2024

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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	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 interview and record review, the facility failed to ensure services were effectively provided a resident admitted without pressure-related skin impairment and identified to be risk to develop pressure injuries to prevent the development of a pressure injury for 1 of 1 resident reviewed for pressure injuries. (Resident M) This deficient practice resulted in Resident M developing a facility-acquired stage two pressure injury on the left buttock that deteriorated to an unstageable pressure injury with infection that required debridement twice, and facility-acquired stage two pressure injuries on the coccyx and right buttock, and a facility-acquired stage one pressure injuries on the right hip. The resident required acute care treatment for wound infection and a new facility-acquired unstageable pressure ulcer was identified on the left upper buttock by hospital staff upon admission. Findings include: On 7/29/24 at 1:17 P.M., Resident M's record was reviewed. Diagnoses included, but were not limited to, hemiplegia on the right side, memory deficits, chronic obstructive pulmonary disease, dementia, and chronic smoker of cigarettes. A quarterly MDS, dated 2/24/2024, indicated Resident M was independent with mobility in his wheelchair and had no pressure areas.	F 0686	**F 686** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident M no longer resides at this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing at the facility have the potential to be affected. Facility skin sweep completed by DNS/Designee: any impairment in skin integrity was added to hot charting, MD and family notification and treatment orders obtained and wound added to wound management. All residents with wounds were assessed for changes/worsening of wound and/or signs and symptoms of infection. MD and family notification if indicated. DNS/Designee reviewed care plans of residents with current wounds to ensure interventions	08/16/2024

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	An untimed Occupational Therapy (OT) Discharge Summary, dated 4/3/24, indicated the resident had received therapy from 1/11/24 to 4/3/24 for assessment of upper extremity strength, functions, wheelchair mobility and propulsion. At discharge, the resident was able to propel his wheelchair with modified supervision for short distances at a time, he required extra time for verbal cues, and encouragements and prompts to correctly use both upper extremities to propel the wheelchair. He was able to utilize hallway rails as needed to assist in wheelchair mobility. He had no issues with sliding or falling out of the wheelchair and was being discharged from OT due to reaching his maximal potential with skilled services. A nurse progress note, dated 4/5/24 at 3:44 p.m., indicated a referral was sent to therapy due to the resident requiring assistance of three staff members to transfer from his wheelchair to bed, inability to use a stand-up lift for transfers, and slouching forward to the right side when up in his wheelchair. There was no care plan revision implemented to address the need for assistance with positioning. No re-assessment of pressure risk was completed. There were no progress notes between 4/3 and 4/8 to indicate a reason for the change in transfer abilities or positioning, any intervention revisions, or interventions initiated. On 4/8/24 at 10:02 a.m., a physician order was obtained for use of a Broda Chair (a chair able to be tipped back to prevent slouching and leaning which required staff assistance to propel). There were no progress notes between 4/8 and 4/11 to indicate the facility had addressed the PI risk or begun monitoring for pressure injury.		specific to meet resident needs. Residents with refusals related to wound care reviewed to ensure specific interventions are identified. RDCS in serviced DNS by 8/13/24 on reviewing facility activity report to identify residents at risk for changes in skin impairment. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In service to be completed per DNS/Designee by 8/14/24 for all licensed nurses on wound care, treatments, documentation and notifying MD and family for changes in appearance/worsening of wounds. All wounds will be reviewed weekly in Nutritionally at Risk meeting, completing IDT weekly wound reviews if indicated and notification of any changing/worsening wound to MD and family. Wound care plans will be reviewed and updated if indicated weekly in NAR meeting. Residents will have a weekly skin assessment, Wound Nurse to follow completion. Resident shower sheets will be reviewed daily in clinical meeting, follow up if indicated. DNS will review facility activity report daily to identify residents at risk for changes in skin impairment, add to clinical	

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	A therapy screen, dated 4/11/2024 at 8:42 a.m., indicated Resident M had a functional change condition and would be evaluated for Physical Therapy related to transfers and lower extremity strengthening. The clinical record did not include was no documentation the therapy screen had been completed between 4/11/24 and 6/10/24. A Wound Management report, completed by the facility wound nurse and dated 4/16/24 at 12:14 p.m., indicated Resident M had a pressure ulcer observed on his left buttock (wound 1) identified on 4/16/24. The wound measured 1.6 cm (centimeters) by 0.8 cm by a depth of 0.1 cm. There was a light amount of serous (clear) drainage and the wound tissue was covered with 100% epithelial tissue (cells that line the external surface of the body). An undated IDT (Interdisciplinary Team) progress note indicated the resident had a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising) pressure ulcer to his left buttock. He had no pain or signs of infection. Contributing factors to the wound development were pressure, moisture, and an increase in incontinence. A treatment order was obtained on 4/16/2024 for the left buttock wound to be cleansed with soap and water, patted dry, Medihoney applied and covered with a bordered gauze. Woundsource.com defined Medihoney as a wound dressing designed to remove necrotic (dead) tissue and an aid to wound healing for pressure areas with partial to full thickness tissue involvement.		meeting review tool and visit residents during Gemba to assess. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bimonthly, and is overseen by the Executive Director. CQI tool identified as Wound CQI will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Date of Completion: 8/16/24	

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	The National Pressure Injury Advisory Panel (NPIAP) website (npiap.com) indicated Stage II pressure injuries are partial thickness injuries with exposed dermal layer (middle layer of skin between the epidermis and other tissue layers), granulation is not present. Stage III pressure injuries are full thickness skin injuries, adipose (fat), granulation (new skin cells) tissues are often present, and the area may have necrotic tissue present. Woundsource.com defined Medihoney as a wound dressing designed to remove necrotic (dead) tissue and an aid to wound healing for pressure areas with partial to full thickness tissue involvement. There was no documentation in the clinical record to indicate an assessment for further pressure injury risk was completed, a care plan developed, or interventions were initiated in response to the discovery of the wound between 4/16/2024 and 4/21/2024. A Wound Management report, dated 4/22/24 at 12:49 p.m., indicated wound on his left buttock continued with no change in measurements. The IDT progress note indicated the resident's wound was stable and staff were to continue to encourage him to lie down between meals. He had no complaints of pain and no changes were made to the treatment of the wound. The report did not include documentation of specific characteristics of the wound bed. There was no documentation in the clinical record to indicate an assessment for further pressure injury risk was completed, a care plan developed, or interventions were initiated related to the facility-acquired pressure injury on the left buttock between 4/22/2024 and 4/29/2024.			

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	A Wound Management report, dated Monday 4/29/24 at 1:42 p.m., indicated the resident refused to lie down to have his wound assessed. There was no documentation to indicate further attempts were made to assess the wound. The care plan was not updated with the resident's refusal of care. The April 2024 Treatment Administration Record (TAR) indicated the treatment for the left buttock wound was not administered in accordance with the physician order on 10 of 16 day shifts between 4/16/24 and 4/30/24. There was no indication in the documentation the resident had been reapproached to attempt wound care during the missed times. The progress notes, dated 4/16/24 through 4/30/24, did not indicate documentation of any attempts made to complete treatments at a different time, nor attempts made to determine cause of the refusals. Resident M was visited by the medical NP on 4/22/24. Progress notes were completed without mention of the resident's wound to his left buttock or refusals of care. A physician visit progress note, dated 5/2/24 at 7:36 a.m., indicated the resident was seen for a chronic care visit. The note indicated the resident had no recent falls, blood pressure was elevated, and should be re-checked by nursing. The resident's weight was stable; and he appeared comfortable with mild chronic pain to his right foot/ankle. The note didn't indicate the resident had a pressure wound to his left buttock nor refusals of treatment by the resident. A Wound Assessment Report by the Wound NP,			

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	dated Friday 5/3/24 at 7:21 a.m., indicated the resident was being seen for a new skin and wound consult. He had a stage II wound to his left ischium/buttock (curved bone forming the base of each half of the pelvis). It measured 4 cm by 2 cm by depth of 0.1 cm and had 100% epithelial tissue covering it with a scant amount of serous drainage. There were no changes made to the treatment. Preventative Measures were to continue pressure reduction and turning and repositioning precautions. The resident was incontinent of bowel and bladder and staff were to use barrier creams after providing thorough skin care for each incontinent episode as well as briefs to manage moisture. The report didn't indicate the wound NP had been notified or aware of the resident's refusals nor his unavailability for wound care on the day shift. A Wound Management report, dated Monday 5/6/24 at 4:27 p.m., indicated the wound on Resident M's left buttock measured 4 cm by 2 cm by 0.1 cm. Contributing factors related to the wound decline were the resident seated in the chair for extended periods of time. Staff were to encourage him to turn and reposition every two hours and a request was made to therapy for a different cushion to his chair. He had no complaints of pain and no changes were made to the treatment of the wound. Resident M's refusals of care were not noted in the report. A Wound Management report, dated Monday 5/13/24 at 2:26 p.m., indicated the assessment had not been completed due to resident's refusal and not wanting to lie down. There were no changes made to the care plan between 4/16/24 and 5/3/24 to assess the resident's refusal of wound care, changes to			

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	timing of wound care per his preferences, pain related to the wound and with treatments, or effects of use of Broda chair such as dependency on staff for ambulation and increased need for assistance with shifting his weight while up in the chair. There were no request/referral documentation for therapy to provide a different cushion for his Broda chair. There were no interventions or descriptions of the wound documented in the clinical record between 5/6/24 and 5/13/24. A Wound Assessment Report by the Wound NP, dated Friday 5/17/24 at 10:02 a.m., indicated the resident's wound was unable to be evaluated on this day due to the resident not being in his room at the time of the visit. There was no indication the resident was reapproached or aware the wound NP was there to see him. There were no interventions or descriptions of the wound documented in the clinical record between 5/13/24 and 5/16/24. A Wound Management report, dated Monday 5/20/24 at 8:30 a.m., indicated the resident's wound was unable to be evaluated on this day due to the resident not being in his room at the time of the visit. A Registered Dietician review, dated 5/20/24 at 9:44 a.m., indicated the resident received a regular diet and was eating and drinking well. He had an open area to his left buttock, was provided a multi-vitamin, double eggs and meat for breakfast and a protein snack at bedtime. He was meeting his nutritional needs with interventions in place. His weight had been down the past 3 months but was not a significant weight change. His BMI was within normal range for his age.			

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A medical NP progress note, dated 5/20/24 at 10:34 a.m., indicated the resident was seen for pain management and reported his pain was well controlled with his current pain medication Xtampza ("an" extended release opioid given the resident every 12 hours routinely for pain). The medication appeared to be effective in controlling his chronic pain and would continue on the medication. There was no documentation regarding the resident's wound or refusals of wound treatment.

A Care Plan Summary form, dated 5/22/24 at 8:51 a.m., indicated the resident's care and care plan was reviewed following a significant change MDS assessment. Neither Resident M nor his POA were at the meeting. There was no documentation the resident or POA were invited or had any concerns. The goal for the resident was to remain within the facility, utilizing a Broda chair. The Care Plan Summary form did not indicate the resident had a new pressure wound to the left buttock, had any refusals of wound treatments or pressure reducing interventions such as lying down between meals.

The May 2024 TAR indicated the treatment for the left buttock wound was not administered in accordance with the physician order on 12 of 24 day shifts and on 1 of 24 night shifts between 5/1/24 and 5/24/24. There was no indication in the documentation the resident had been reapproached to attempt wound care during the missed times.

A significant change MDS (Minimum Data Set) assessment, dated 5/10/24, indicated the resident had severely
impaired cognition. He had several mood

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	indicators, present nearly every day. This included: little interest or pleasure in doing things, feeling down, depressed, or hopeless, trouble falling or staying asleep, and poor appetite. The MDS indicated he had no refusals of care, was dependent on two staff for mechanical lift transfers in and out of bed and was dependent on 1 staff for mobility in his wheelchair, and he was always incontinent of bowel and bladder. The MDS indicated the resident had a new facility acquired stage II wound on the left buttock. Care plans, reviewed and revised on 5/22/24, indicated the following: -Impaired skin integrity: the resident had an open area to the left buttock with contributing factors of incontinence, stroke with right side hemiplegia, shearing, behaviors, and non-compliant with wound care/medications. The goal was for the wound to heal and be free from signs of complications. Interventions were: assess for pain/treat as ordered and notify MD (Medical Doctor) of worsening/unrelieved pain, assess wound weekly documenting measurements and description, encourage resident to eat at least 75%, labs as ordered, notify MD of worsening or no change in wound or signs of infection, observe for signs of infection: redness, pain, drainage, malodorous drainage, fever, increase in size/depth of wound, pressure reducing cushion to chair, pressure reducing mattress on bed, RD (Registered Dietician) to assess routinely, supplements as ordered, turn and reposition every 2 hours, and wound healing vitamins and treatment as ordered. The care plan did not address the resident's noncompliance or provide interventions to prevent pressure ulcer development, deterioration or provide pressure relief to the left buttock.			

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	-At risk for further skin breakdown in the current pressure area on the left buttock due to hemiplegia, dementia, and chronic pain. The care plan indicated he was at moderate risk, according to the Braden Scale for Predicting Pressure Sore Risk, due to a slighted limited ability to respond to pressure related discomfort, occasionally moist skin, being chairfast and only able to make occasional slight changes in body position, nutrition probably inadequate, only occasional acceptance of a dietary supplement when offered, and potential problem with friction and shear when being assisted to reposition. The goal was to be free from skin breakdown. Interventions included: assess and document skin condition weekly, as needed and house barrier cream to be used as needed. The care plan did not address the resident's increased risk due to noncompliance or provide interventions to prevent pressure ulcer development, deterioration or provide pressure relief to the left buttock. -Nutritional status: at risk for altered nutrition and unintentional weight change due to varied meal intakes, chronic disease, and pressure area to left buttock. The goal was for the resident to maintain his current weight without significant weight changes although gradual long-term weight loss to his UBWR (usual body weight range) was acceptable (UBWR=175-180 pounds). Interventions included: provide diet as ordered-regular, double eggs and meat with breakfast. -The resident required assistance with his ADL's (activities of daily living) bed mobility, transfers, eating and toileting. Interventions included: Assist with ambulation as needed utilizing a Broda chair. The care plan did not address the			

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	increased risk of pressure area related to the Broda chair or provide interventions to prevent pressure ulcer development, deterioration or provide pressure relief to the left buttock. A Wound Assessment Report by the Wound NP, dated Friday 5/24/24 at 7:11 a.m., indicated the resident was seen for continued evaluation of a wound on his left buttock. The wound had worsened and was unstageable (Pressure ulcers that have eschar [tan, black, or brown] or slough [yellow, tan, gray, green or brown] tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed). The wound measured 2 cm by 1.5 cm by 0.1 cm. The wound base was covered with 25% slough and 75% eschar, the wound edges were attached, periwound had scarring, and there was no drainage. Treatment orders were changed to applying Santyl (chemical removal of dead tissue) followed by bordered gauze, then change daily. The resident's risk for complications was moderate due to decreased mobility, disease comorbidities, incontinence of urine and stool, and impaired nutrition. The Wound NP report didn't indicate the resident missed wound treatments at times due to being unavailable or refusing treatment. A physician order, dated 5/24/24, was for the left buttock wound to be cleansed with soap and water, patted dry and Santyl (a wound dressing designed to remove necrotic tissue) applied and covered with bordered gauze 2 times per day which were scheduled to be done between 2:00 p.m. - 10:00 p.m. and again, between 10:00 p.m. - 6:00 a.m. The May 2024 TAR indicated the treatment for the left buttock was not administered in accordance with physician order on 4 of 24 day shifts and on			

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	2 of 24 night shifts between 5/2/24 and 5/31/24. There was no indication in the documentation the resident had been reapproached to attempt wound care during the missed times. The clinical record did not include documentation, between 4/16/24 and 5/24/24, to indicate the facility-acquired pressure wound bed included necrotic tissue. There were no further assessments, progress notes or care plans regarding the left buttock wound between 5/22/24 and 5/24/24. A Wound Management report, dated Monday 5/27/24, indicated the residents facility-acquired unstageable pressure wound had worsened in size; now measured 2 cm by 1.5 cm by 0.1 cm and the wound bed was covered with necrotic tissue. Contributing factors related to wound worsening were pressure and the resident refusing to lay down between meals. The new intervention was a change in the wound treatment. There were no new interventions to provide pressure relief to the left buttock added to the care plan. On 5/30/24 at 9:57 a.m., the resident was seen by the medical NP for chronic care management with a left buttock wound and chronic pain. The resident had a left buttock wound with treatment currently in place. Staff were to reposition the resident to alleviate pressure and potentially reduce pain. Wound care would be provided to promote healing and prevent infection. His nutritional status would be monitored to ensure adequate intake for wound healing. The note didn't indicate the medical NP had been notified of the resident's refusal of care or his being unavailable for wound treatments to be completed as ordered.			

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	A Wound Assessment Report by the Wound NP, dated Friday 5/31/24 at 6:49 a.m., indicated the resident was seen for the pressure wound on his left ischium. The wound measured 2.2 cm by 3 cm by 0.1 cm and was unstageable. The wound bed was covered with 75% slough, 25% eschar and had a scant amount of serous drainage. The wound was mechanically debrided (physical removal of necrotic tissue) with use of a scalpel and forceps. 100% of the wound was debrided of necrotic tissue. New recommendations were to continue to treat the wound with Santyl, obtain low air loss mattress, and cushion for the wheelchair. His risk for complications remained moderate. The note didn't indicate the wound NP had been notified of the resident's refusal of care or of his being unavailable for wound treatments to be completed as ordered. There were no new interventions added to the care plan to provide pressure relief to the left buttock after deterioration was identified. A TAR, dated June 2024, indicated physician orders, dated 5/24/24 and discontinued 6/10/24, were for the left buttock wound to be cleansed with soap and water, patted dry and Santyl applied and covered with bordered gauze 2 times per day which were scheduled to be done between 2:00 p.m. - 10:00 p.m. and again, between 10:00 p.m. - 6:00 a.m. The TAR indicated the treatments had not been completed as ordered between 2:00 p.m. - 10:00 p.m. on 6/1 and 6/2/24. There was no indication in the documentation the resident was reapproached to attempt wound care during the missed times. A Wound Management report, dated Monday 6/3/24 at 7:09 p.m., indicated the residents wound measured 2.2 cm by 3 cm by 0.1 cm. It was unstageable due to slough and eschar and had			

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	light serous drainage. There was no IDT note completed or new interventions put in place. There were no interventions or descriptions of the wound documented in the clinical record between 5/27/24 and 6/3/24. A Wound Assessment Report by the Wound NP, dated Friday 6/7/24 at 7:30 a.m., indicated the resident was seen for follow up care to his pressure wound to his left ischium (wound 1). Santyl for enzymatic debridement had been used, revealed more depth and necrotic tissue to the wound. The report indicated the Wound NP was still unable to get the true depth of the wound. The wound was unstageable and measured 2.2 cm by 3.6 cm by depth of 3.1 cm with a moderate amount of serosanguineous (blood and liquid) drainage. The wound bed was covered with 75% slough and 25% eschar with scarring at the periwound. The wound was mechanically debrided with use of a scalpel and forceps. 100% of the wound was debrided of necrotic tissue. Nursing staff were given detailed ulcer care instructions and asked to monitor the ulcer for signs or symptoms of prolonged bleeding and debridement intolerance. The plan was to cleanse the wound with 0.125% Dakins solution (topical antiseptic to treat and prevent infections in wounds); apply Santyl and Dakins moistened fluffed gauze to base of the wound; secure with a bordered gauze dressing and change daily. Recommendations were to continue ongoing pressure reduction and turning/repositioning precautions per protocol. All prevention measures were discussed with the staff at the time of the visit. Resident M's risk for complications remained moderate. The note didn't indicate the wound NP had been notified of the resident's refusal of care or pressure reducing interventions.			

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There were no other assessments between 4/16/24 and 6/7/24 to show the facility re-assessed the resident's risk to develop additional pressure wounds.

A Wound Management report, dated Friday 6/7/24 at 10:36 a.m., indicated Resident M had new wounds observed. He had a stage II pressure ulcer on his coccyx (wound 2) which measured 2 cm by 1.5 cm by 0.1 cm with light serous drainage. He had a stage II wound to his right buttock (wound 3) which measured 2 cm by 2.5 cm by 0.1 cm and had serous drainage. A third unstaged pressure wound (wound 4) was observed on his right hip which measured 5.5 cm by 6.5 cm with no depth and was red in color.

There was no documentation in progress notes or management reports completed to indicate the physician, medical NP, wound NP, or family had been notified of the new wounds or treatment orders obtained when the wounds were observed on 6/7, nor any follow up on 7/8 or 6/9/24. There was no documentation completed on the resident's wounds, pain, or adherence to implementation of pressure reducing interventions on 6/8 or 6/9/24.

The TAR, dated June 2024, did not indicate the wound treatment ordered by the wound NP on 6/7/24 to cleanse the wound with 0.125% Dakins solution followed by Santyl and Dakins moistened fluffed gauze to base of the wound, secure with a bordered gauze dressing and change daily was initiated between 6/7/24 and 6/10/24 to show the treatment was completed as ordered.

A nurse progress note, dated 6/10/24 at 11:24 a.m., indicated Resident M had been transported to the

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	hospital per EMS at family request due to pressure areas. Hospital Emergency Room records, dated 6/10/24 at 12:11 p.m., indicated the resident was seen in the emergency room for multiple pressure ulcers and evaluation of two pressure ulcers which had worsened. EMS reported the resident had increased pain and upon arrival in ER. The coccyx ulcer (wound 2) on the left showed full skin and tissue loss with possible tunneling and eschar over the wound base with potential surrounding cellulitis. He was started on intravenous antibiotics, blood work was obtained and a CAT (X rays using a computer to define bones and soft tissues) scan ordered. He had no signs of secondary infection at the time of assessment. A hospital CAT scan, completed on 6/10/24 at 4:05 p.m. indicated the resident had a large soft tissue ulcer along his left posterior soft tissues with overlying edema (swelling) and a questionable midline ulcer over his coccyx. The CAT scan could not rule out a bone infection where the ulcers were located and MRI was to be considered for further evaluation but not done due to presence of metal in his body from an old injury. Wound Physician assessment indicated complete healing of the wounds could be attempted with routine follow up but potential to heal was poor. Factors which likely contribute to non-healing included lack of adequate off-loading when seated and supine, recurrent infection, repeated unintentional trauma, lack of adequate nutrition, dementia, and inability to offload with contractures present. Pressure wounds, documented on 6/10/24 with photographs and measurements, observed in the emergency room,			

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	were further evaluated on 6/11/24 by the wound care consultant. The left ischium (wound 1) pressure wound-last documented on and measured by the facility wound NP on 6/7/24-measured 3 cm by 4 cm with unknown depth due to the wound being open but covered with eschar. A pressure injury to the mid-sacral/coccyx (wound 3) area-identified at the facility on 6/7/24 with no treatment ordered and measuring 2 cm by 1.5 cm by 0.1 cm-was a stage II wound which was moist, open and measured 1.5 cm by 1 cm by depth of 0.3 cm with a small amount of tan drainage with a faint odor. A pressure injury to his lateral right hip (wound 4) wound -identified at the facility on 6/7/24, as an abrasion which measured 5.5 cm by 6.5 cm-presented as a stage II wound that measured 6.7 cm by 7.5 cm. The wound was open with slough and moderate tan/brown drainage which had a faint foul odor. An unstageable pressure injury to the residents left upper buttock (wound 5), which was present upon admission but not identified by the facility, measured 0.5 cm by 1 cm and was dry and covered with eschar. The resident remained in the hospital for 9 days and was discharged to a long term care facility located nearer to family. The Hospital note did not include sufficient information to determine wound 3 on the right buttock was assessed. An Indiana Department of Health complaint intake, dated 7/16/2024, indicated Resident M had been neglected and subsequently developed multiple pressure ulcers. This resulted in hospitalization of treatment of his wounds. On 7/29/24 at 10:29 A.M., Resident M's POA (Power of Attorney) was interviewed. They indicated the resident had been hospitalized 9 days for treatment of his pressure ulcers developed at the facility. Following hospitalization, the resident was moved to a			

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	different nursing home closer to the POA. On 7/29/24 at 2:21 P.M., Nurse 2 was interviewed. She indicated when residents refused a wound treatment, she would ask why they were refusing, ask if there was a better time for the treatment to be done, reapproach them, ask about pain, hunger, thirst, or try and have another nurse complete the treatment. -At 2:24 P.M., Nurse 3 was interviewed. The TAR indicated Resident M usually refused to have wound treatment completed by Nurse 3. The nurse indicated she asked residents three times and when they refused a treatment, she documented it in the nurse progress notes and let the Director of Nursing Services (DNS) know. There was no documentation available for review regarding Resident M's refusals or the notification of the DNS. -At 2:26 P.M., the DNS indicated staff should reapproach a resident later when they refuse a treatment and notify the physician for continued refusals. When asked about the physical therapy evaluation, on 4/11/24, and new order for the Broda chair, the DNS indicated the physical therapy referral had not been completed as recommended. No reason was given related to the therapy assessment of the Broda chair. On 7/30/24 at 10:53 A.M., the DNS, Administrator, and RDCS (Regional Director of Clinical Services) were interviewed. The DNS indicated the resident resided in the facility since 2019 and never had any wounds/pressure areas. She indicated the resident had been declining with weight loss and little appetite. Resident M frequently refused care and preferred to stay in his chair all day so he could smoke during smoke times. When asked,			

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	the DNS indicated the POA was aware of the resident's refusals of care though there wasn't documentation completed about the refusals. There was no documentation to indicate attempts were made to offer different times for wound care according to his preferences. The DNS, Administrator, and RDCS agreed the POA hadn't been notified of the residents new wounds identified on 6/7/24, but the NP had been made aware despite lack of documentation. The DNS indicated the resident's care plan indicated the resident had a pressure ulcer and was non-compliant with wound care/medications; however, there were no interventions put in place to address his refusals. There was no documentation to indicate attempts had been made to alter the times his treatments were scheduled so he would agree to lie down between meals and gotten back up for smoke breaks. There was no documentation the POA or resident had been notified of the consequences of refusing wound care and potential for further skin breakdown to occur. On 7/30/24 at 11:11 A.M., the SSD (Social Service Director) was interviewed. She indicated refusal of care, was documented in the progress notes or on forms titled new and worsening behaviors and communication forms which were available in the record for staff to complete. She indicated she would get involved with refusals of care when it became a problem but provided no further clarification on what was considered a problem. She reviewed progress notes, new and worsening behavior forms and communication forms for April, May, and June 2024 and indicated there had been no documentation of the resident refusing care. She indicated she wasn't aware of the resident's refusals which had impacted his wound care.			

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	On 7/30/24 at 11:22 A.M., the wound care nurse was interviewed. She indicated managers reviewed wounds in their daily morning meetings including the progress of wound healing. She would complete wound measurements and observations on Fridays with the Wound NP as she did her rounds, then would document the visit, wound measurements, and interventions on the Monday following the Friday visit. When asked, she was unsure why the order for Dakins solution, ordered on 6/7/24, hadn't been documented on the TAR and started immediately. The wound nurse indicated she wrote down the assessment of the Wound NP to complete her documentation. A current facility policy, titled "Skin Management Program", was provided on 7/30/24 at 10:53 A.M., which stated: "It's the facility policy to ensure... 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...Procedure for Alteration in Skin Integrity-Pressure and Non-Pressure: Alterations in skin integrity will be reported to the MD/NP, the resident and/or resident representative as well as to direct care staff. Treatment order will be obtained from MD/NP...A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented...For a resident who declines treatment, the IDT or designee must discuss with the resident and/or resident representative, the resident's			

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	condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility is expected to address the resident concerns and offer relevant alternatives if the resident has declined the specific treatments...."This citation relates to Complaint IN00438838.3.1-40			