STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155798	A. BUILDING 00 B. WING	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00404416 and IN00404800. Complaint IN00404416 - Federal/state deficiencies related to the allegations are cited at F684 and F691. Complaint IN00404800 - No deficiencies related to the allegation are cited. Survey dates: April 11 and 12, 2023 Facility number: 012861 Provider number: 155798 AIM number: 201080610 Census Bed Type: SNF/NF: 75 SNF: 33 Total: 108 Census Payor Type: Medicare: 33 Medicaid: 65 Other: 10 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 13, 2023	F 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is provided as evidence of the facilities desire to comply with regulations and continue to provide quality care. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jaime Sevier	RN	04/24/2023

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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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to follow physician for follow up wound care for 1 of 3 residents reviewed (Resident D). Findings include: On 4/11/23 at 10:08 A.M., Resident D's record was reviewed. Diagnoses included, abdominal surgical wound infection and ileostomy (stoma made by bringing a part of the intestine out on the surface of the skin) dysfunction. She was admitted to the facility following prolonged hospitalization resulting from a large abdominal surgical wound. The wound was chronically infected due to near constant leaking of her ileostomy. An admission MDS (Minimum Data Set) assessment, dated 2/21/23, indicated the resident had no cognitive impairment. She required assistance with her activities of daily living and had an ostomy. She had a surgical wound and received surgical wound care. Care plans were: -Resident D had a surgical wound with complications to the abdomen and wound separation. The goal was for the surgical wound to heal with care plan interventions. Interventions included the resident would be referred to consulting physicians as indicated and treatments completed as ordered.	F 0684	Resident D no longer resides at the facility. All other residents that require surgical wound care have the potential to be affected by this deficient practice. All current residents with surgical wound areas were reviewed to ensure appropriate treatments were ordered including wound clinic referral as indicated. The facility policy and procedure for PCC Wound Care and Documentation was reviewed and no changes were indicated. Facility nursing staff were reinserviced by the Director of Nursing regarding the facility policy and procedure for PCC Wound Care and Documentation. One on One education was provided to the facility Wound Care Nurse by the Regional Director of Quality Assurance and the facility Director of Nursing. The DON and/or designee will randomly complete the Wound Review Quality Assurance form. The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive	04/28/2023

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	-Resident had an ileostomy. Interventions included: ostomy care to be completed as needed, observe and report ostomy appliance being loose or dislodged. Admission orders from the hospital, dated 2/17/23, were for the resident to be referred to the wound clinic for continued care of her surgical wound and leaky ileostomy. There were no orders for surgical wound care to the abdominal incision. Physician and NP (Nurse Practitioner) progress notes indicated the following: -2/20/23 at 4:04 p.m., the resident was seen for an initial history and physical. She'd been hospitalized for an extended period of time during which a ileostomy had been placed as well as a wound vac to a non-healing large abdominal surgical wound. The wound vac was removed due to inability to stick to resident's skin related to persistent leaking of the ileostomy. Routine wet to dry dressings were done for wound care. She was then sent to the facility for physical therapy and wound care. She had considerable skin irritation around her ostomy site and the ileostomy drained copious amounts of thin liquids. She had a very large dressing over the mid to lower left abdominal wound cared for by the facility wound care team. Assessment and Plan: Abdominal wall wound infection: she would continue with wound care at the facility and was scheduled for follow up at the wound clinic. -2/21/23 at 1:12 p.m., Resident to continue wound care at facility and follow up with wound clinic for her very deep abdominal wound. -2/22/23 at 12:03 p.m., Resident to continue wound care at facility and follow up with wound clinic. -2/23/23 at 11:20 a.m., Resident to continue wound care at facility and follow up with wound clinic.		months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the SSD and/or designee will randomly complete the Wound Review Quality Assurance review form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	

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	-2/24/23 at 11:31 a.m., Resident's skin around stoma and surgical wound was excoriated and painful. She continued with issues of ileostomy leaking. Resident to continue wound care at facility and follow up with wound clinic. -2/27/23 at 2:43 p.m., Resident's abdominal wound was stable and managed by the wound care team at the facility. She would continue wound care with staff on a regular basis and follow up with wound care clinic. Review of physician orders and the TAR (Treatment Administration Record) dated February 2023, hadn't indicated wound care orders or the resident's abdominal surgical wound treatment or dressings to be applied. On 4/11/23 at 2:44 P.M., the Certified Wound Care Nurse was interviewed. He hadn't indicated what treatment was being completed for the resident's abdominal surgical wound but indicated the referral to the wound clinic had not been completed as ordered. On 4/12/23 at 10:30 A.M., the Regional Nurse Consultant was interviewed. She indicated staff should have gotten physician orders for the surgical wound care and documented care given in the TAR. Nursing staff should have followed physician orders and made an appointment at the wound clinic for continued care. A current facility policy, titled "PCC Wound Documentation Protocol" was provided by the Regional Nurse Consultant on 4/11/23 at 11:00 A.M., which stated:"...The licensed nurse is responsible for notifying the physician of changes in the wound condition...Physician ordered treatments will be documented on the TAR after each administration...."			

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	This Federal tag relates to Complaint IN00404416. 3.1-37			
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to provide necessary care and services for management of an ileostomy for 1 of 3 residents reviewed (Resident D). Findings include: A concern, submitted to the Indiana Department of Health on 3/21/23, indicated Resident D was seen at the office of the Infectious Disease physician for follow up related to an infected abdominal surgical wound. When she arrived at the physician's office, her ileostomy bag was observed to be leaking liquid stool into her abdominal surgical wound. She was immediately sent and admitted to the hospital. The concern alleged the resident's ileostomy would leak continually. She was left lying in stool covered towels until staff could change the ileostomy bag. The resident was alleged to believe she was at the bottom of staff's to-do list because it time consuming to clean her, the abdominal wound, and change the ileostomy bag. A copy of a progress note by an Infectious Disease physician, was submitted with the concern. The note	F 0691	Resident D no longer resides at the facility. All other residents that require colostomy/ileostomy care have the potential to be affected by this deficient practice. All current residents with a colostomy/ileostomy were reviewed to ensure appropriate wound care and colostomy/ileostomy management was completed. The facility policy and procedure for Colostomy/Ileostomy Care was reviewed and no changes were indicated. Facility nursing staff were reinserviced by the Director of Nursing regarding the facility policy and procedure for Colostomy/Ileostomy Care. The facility nurses were reinserviced regarding the competency skills observation for Colostomy/Ileostomy Care. The DON and/or designee will randomly complete the	04/28/2023

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	indicated the resident had continuous contamination of her left sided abdominal wound due to poorly sealed adjacent ostomy bag. This resulted in constant contact dermatitis and recurrent cellulitis (soft tissue infection) due to contact with liquid stool. On 4/11/23 at 10:08 A.M., Resident D's record was reviewed. Diagnoses included, abdominal surgical wound infection and ileostomy (stoma made by bringing a part of the intestine out on the surface of the skin) dysfunction. She was admitted to the facility following prolonged hospitalization related to an infected abdominal surgical wound adjacent to a leaking ileostomy. She was prescribed intravenous antibiotics to treat the infection. While hospitalized, she received care from wound clinic staff who managed her ileostomy and surgical abdominal wound. Upon admission to the facility, she was ordered to return to the wound clinic for follow up wound care and ileostomy management. An admission MDS (Minimum Data Set) assessment, dated 2/21/23, indicated the resident had no cognitive impairment. She required assistance with her activities of daily living and had an ostomy. Care plans were: -Resident had an ileostomy. Interventions included: ostomy care to be completed as needed and observe and report ostomy appliance being loose or dislodged. A nurse progress note, dated 2/19/23 at 12:32 p.m., indicated the resident's ileostomy bag was leaking copious amounts of stool onto the residents abdomen and into her surgical abdominal wound.		competency skills observation for Colostomy/Ileostomy Care. The random observation will be completed with 3 nurses weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the skills observation for Colostomy/Ileostomy Care form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	

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	The resident complained of much pain while the ileostomy bag and dressing to abdominal wound were changed. -1:23 p.m., a complete ileostomy bag change and wound care was completed again due to leakage of the bag. A physician progress note, dated 2/20/23 at 4:04 p.m., indicated the resident was seen for an initial history and physical. She'd been hospitalized for an extended period of time during which an ileostomy had been placed as well as a wound vac to a non-healing large abdominal surgical wound. The wound vac had been removed due to inability to stick to the resident's skin because of persistent leaking of the ileostomy. She was then sent to the facility for physical therapy and wound care. She was observed to have considerable skin irritation around her ostomy site as the ileostomy drained copious amounts of thin liquids. She had a very large dressing over the mid to lower left abdominal wound. Assessment and Plan: Status Post Ileostomy: the ileostomy continued to function but had been leaking a fair amount. The resident was to continue to work with the ostomy. The resident was to continue wound care at the facility and follow up with wound care clinic. A physician progress note, dated 2/21/23 at 1:12 p.m., indicated the resident's ostomy function was stable but her stool was still watery. A nurse progress note, dated 2/22/23 at 3:37 p.m., indicated the resident's ileostomy was changed 2 times; watery diarrhea continued. This caused the ileostomy bags to fall off. On 2/23/23 at 11:20 a.m., an NP (Nurse Practitioner) progress note indicated the resident			

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	had a follow up visit. The resident reported she had found some ostomy bags online and was having them delivered the next day. She was to continue wound care at facility and follow up with wound clinic. On 2/24/23 at 11:31 a.m., an NP progress note indicated the resident's skin around her stoma and surgical wound was excoriated and painful. She continued with issues of her ileostomy leaking and had a hard time getting the ileostomy bags to stay in place. Nursing staff were to continue to work on this difficulty. She was to continue wound care and follow up with the wound care clinic. A physician progress note, dated 2/27/23 at 2:43 p.m., indicated the resident's abdominal wound was stable. She would continue with wound care and follow up with the wound care clinic. Admission orders from the hospital, dated 2/17/23, were for the resident to be referred to the wound clinic for continued care of her surgical wound and leaky ileostomy. Orders were to change the resident's ileostomy bag every 3 days and as needed. There was no documentation to indicate what interventions had been attempted to find an ileostomy bag to would stick to the resident's skin, to treat the excoriation around the resident's ostomy or how staff were to protect the resident's surgical wound from contamination by liquid stool that came out of the ostomy. On 4/11/23 at 2:44 P.M., the Certified Wound Care Nurse was interviewed. He indicated the referral to the wound clinic for wound and ostomy care had not been completed as ordered. When questioned, he indicated his job as a Wound Care Nurse hadn't involved ostomy care although he			

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	had provided suggestions to the nursing staff for placement of the resident's ileostomy bags to prevent leakage. A current facility policy, titled "Colostomy/Ileostomy Care", was provided by the Regional Consultant Nurse on 4/12/23 at 11:00 A.M., and stated: "Purpose: to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter...observe the stoma and surrounding area. Note the following: breaks in the skin; excoriation; signs of infection (heat, swelling, pain, redness, purulent exudates...." This Federal tag relates to Complaint IN00404416. 3.1-47(a)(3)			