STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING 00 B. WING	09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00417488. Complaint IN00417488 - Federal/state deficiencies related to the allegations are cited at F684. Survey dates: September 18, 2023 Facility number: 000388 Provider number: 155807 AIM number: 100454140 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicaid: 29 Other: 2 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 22, 2023	F 0000		
F 0684 SS=G 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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla Rosselot	MSN RN DON	09/29/2023

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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	comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident that was identified with an alteration in skin integrity had an assessment conducted upon identification of the skin impairment, upon readmission to the facility, and weekly thereafter. The facility also failed to implement a treatment timely and continued treatment to a skin alteration that was later identified with osteomyelitis that required hospitalization, intravenous antibiotic therapy, and surgical intervention for 1 of 1 resident reviewed for skin impairment. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/18/23 at 12:04 p.m. The diagnoses included, but were not limited to, senile degeneration of brain, diabetes mellitus, major depressive disorder, vascular dementia, and muscle weakness. A progress note, dated 4/27/23 at 3:50 p.m., indicated the following, ""...Was reported to this writer by skin nurse that this resident had a "Loose toe nail." Upon visualization of area, noted Lt [left] GR [great] toenail bed very loose and a new nailbed underneath...." A progress note, dated 5/2/23 at 3:58 p.m., indicated the following, "...Contacted [name of wound care company] physicians for wound consult on L [left] Gr [great] toe and possible debridement of toe nail...." There were no treatment orders for Resident B's left great toe and/or toenail in April of 2023.	F 0684	**Deficiency F684 S/S G** **Quality of Care** **Based on interview and record review, the facility failed to ensure a resident that was identified with an alteration in skin integrity had an assessment conducted upon identification of the skin impairment, upon readmission to the facility and weekly thereafter. The facility also failed to implement a treatment timely and continued treatment to a skin alteration that was later identified with osteomyelitis that required hospitalization, intravenous antibiotic therapy, and surgical intervention of 1 of 1 resident reviewed for skin impairment.** **1 Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** **a** DON/designee will in-service all nurses to include assessments: **i** upon admission/readmission **ii** upon change in condition, **iii** weekly skin assessments, **iv** weekly wound assessments and measurements	10/08/2023

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	A physician order, dated 5/2/23, indicated the following, "...Check that Left FT [foot] is wrapped with kerlix and secured with tape. Do not remove dressing until foot is assessed by [name of physician]...." The order was discontinued on 5/18/23. A podiatrist note, dated 5/17/23, indicated the following, "...Pain on left great toe...Nails are L [left] great toe trauma bloody, Lifted, loose, yellow drainage with Hematoma at base of toenail on left great toe...Skin Details: L great toe trauma yellow drainage...Comments: Total nail avulsion and incise and drain hematoma...Debrided using 15 blade followed by Betadine scrub then normal saline rinse. 2x2 sterile betadine gauze applied...Orders written for Keflex 500mg [milligrams] PO [by mouth] TID [three times daily] x10 days followed by dressing changes from wound care team until healed...." A physician order, dated 5/17/23, was noted for Keflex 500 mg three times daily. Upon review of the electronic medication administration record (EMAR) for May of 2023, there were 5 holes for the Keflex administration out of 30 administrations. A physician order, dated 5/18/23, was noted for Betadine to left great toe dated from 5/18/23 to 5/27/23. There were no reassessments of the area to Resident B's left great toe to determine if the area had healed, continued, or worsened for May of 2023 and June of 2023. A progress note, dated 6/8/23 at 11:50 a.m., indicated the following, "...DTI [deep tissue injury] on L [left] heel, dry skin. No other skin		**v** documentation of skin conditions **vi** who to report new skin conditions to **b** DON/designee will in-service all nurses/QMAs on medication administration per physicians' orders. **2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** **a** DON/designee will complete a skin sweep of the entire facility. Any findings will be documented on a skin sheet and placed in a chart of record. **b** Don/designee will complete nursing assessments on all residents and document appropriately. **c** DON/MDS/designee will update care plans accordingly. **3 Address what measures will be put into place or systemic changes made to ensure that the deficient practices will not reoccur.** **a** DON/designee will assign weekly skin assessments for each resident to nursing staff. **b** DON/designee will audit 5 random charts to ensure weekly skin assessments are completed and medications are administered per MD orders. The charts audited will include admission/readmissions, change in conditions, wounds, and	

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	concerns...." There was no further assessment of Resident B's left heel. The EMAR for June of 2023 did not note any physician orders for treatment of the left great toe or the left heel of Resident B. A progress note, dated 7/3/23, indicated the following, "...Resident transferred to [name of hospital] noted left great toe with darkened skin appearance, abrasions, small amount of blood noted on sock. Resident states his foot is painful...." A progress note, dated 7/14/23 at 3:28 p.m., indicated Resident B returned from the hospital. Hospital notes, dated 7/3/23 to 7/14/23, indicated Resident B had a diagnosis of subacute osteomyelitis of left foot and was administered intravenous antibiotics. A podiatry note, dated 7/11/23, indicated a pressure ulcer to the left heel and a diabetic ulcer to the left hallux. The plan noted "Discussed with patient Left hallux amputation and Left heel debridement for tomorrow 7/12 at 1700 [5:00 p.m.], patient was amendable...." There was no skin assessment to reflect any skin concerns or document on the existing skin concerns to Resident B's left heel and left great toe upon readmission on 7/14/23. A progress note, dated 7/14/23 at 3:28 p.m., indicated the following, "...Resident returned from [name of hospital]...Pt [patient] had greater left toe amputated...." A progress note, dated 7/15/23 at 6:54 a.m., indicated the following, "...F/U [follow-up]		documentation. **c** This random audit will be conducted: **i** Every working day x 4 weeks **ii** 2x/week X 4 weeks **iii** Weekly X 4 weeks **iv** Monthly x 4 months **4 Indicate how the facility plans to monitor its performance to make sure that the solutions are lasting.** **a** Any negative trends will be reviewed in monthly QAPI meetings. After 6 months, the IDT will determine the need and /or frequency of continued monitoring. **b** DON/designee will continue the above audit process once quarterly as an ongoing practice. **5 Date of completion** **a** October 8, 2023	

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	charting from readmission. Pt did not have great l [left] toe amputated. Received inaccurate report from [name of hospital]. Pt does still have toe intact however it is wrapped up in bandage...." There was no assessment conducted upon Resident B's readmission to the facility that would include a skin assessment. A progress note, dated 7/18/23 at 3:26 p.m., indicated the following, "...Resident reviewed post hospital 7/3 to 7/14 following amputation of left great toes, debridement of left heel and reported PU [pressure ulcer] coccyx. He was treated with antibiotic for osteomyelitis and continues to receive oral antibiotic...." There were no skin treatments on Resident B's medication and/or treatment administration record (MAR/TAR) for July of 2023. There were no physician orders for a weekly skin assessment to be conducted for July of 2023. A progress note, dated 8/1/23, indicated the following, "...reviewed with the nurse. Resident did NOT have left gr. [great] toe amputated...." All Resident B's wound notes from the wound center were obtained via fax by the Director of Nursing, on 9/18/23 at 1:52 p.m. A wound consult from the wound center, dated 8/1/23, indicated that was Resident B's initial visit to the wound center. The diagnosis was listed as type 2 diabetes mellitus with foot ulcer. The note indicated the following from the hospital, "...07/13/23...Diabetic Ulcer...Great Toe...Incision Closure Method...Sutures...." The left heel ulcer was debrided at that time. A dressing was applied and meant to stay in place for one week until seen			

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	again. A wound center note, dated 8/8/23, indicated a diabetic ulcer to left great toe and left heel. Both wounds underwent debridement, and a dressing was applied to stay in place for one week. A wound center note, dated 8/15/23, indicated the wounds to Resident B's left great toe and left heel underwent debridement, and a dressing was applied to stay in place for one week. A progress note, dated 8/22/23 at 11:04 a.m., indicated Resident B was sent out to the hospital due to being lethargic and difficult to arouse. A progress note, dated 8/25/23 at 10:05 p.m., indicated Resident B returned from the hospital and noted to have a "small open area noted on coccyx and scrotum area". There was no assessment conducted upon Resident B's readmission to the facility that would include a skin assessment. A progress note, dated 9/1/23 at 8:19 a.m., indicated the following, "...Upon assessment this patient seems to have a stage 2 pressure wound to his right hip measuring 6x4 cm [centimeters]...." There were no further assessments conducted for this skin impairment. A care plan for skin, initiated 9/18/23, indicated the following, "The resident has Amputation of R [right] first joint of L [left] toe r/t [related to] diabetes". There wasn't a care plan given by the DON that was dated prior to 9/18/23. An interview conducted with the DON, on 9/18/23 at 12:41 p.m., indicated (name of wound consulting company) had not been out to the			

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	facility. Since Resident B was the only resident with a wound, they would only do telehealth visits. We got the contract put together and before we could use their services, Resident B passed away. Another interview conducted with the DON, on 9/18/23 at 1:55 p.m., indicated she just retrieved wound notes for Resident B from (name of wound center). Not all the wound center notes were located in Resident B's chart. She was not able to locate any readmission assessments for Resident B dated 7/14/23 or 8/25/23. There was no weekly wound and/or skin assessments located in Resident B's clinical record. The expectations are for staff to conduct weekly skin assessments on paper along with the weekly wound assessments if a resident has one. A policy titled "Decubitus Ulcers (Pressure Sores)", undated, was provided by the DON on 9/18/23 at 1:54 p.m. The policy indicated the following, "...Pressure sores will be assessed and treated according to facility policy and/or physicians orders. This is to assure that Resident's having pressure sores will receive necessary treatment to promote healing, prevent new sores from developing, and prevent infection...PROCEDURE...1. A licensed nurse will assess each Resident for decubiti on admission...2. Each decubiti will be documented on the appropriate facility form...3. Treatment orders will be obtained...4. Ongoing measurements shall be obtained by a designated, qualified person...5. An entry is to be made on the Resident care plan relative to skin condition. This entry should include location and stage...." This Federal tag relates to Complaint IN00417488.			

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	3.1-37(a)			