STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY SHELBYVILLE, IN 46176

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00410833. Complaint IN00410833. State deficiency related to the allegations is cited at R0036. Survey date: June 19, 2023 Facility number: 014548 Residential Census: 44 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on June 20, 2023	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify the attending medical provider of a change in the resident's skin condition, prior to instituting new care and/or services for 2 of 3 residents reviewed in change in condition or care status. (Residents B and D) Findings include:	R 0036	ul class="BulletListStyle1 SCXW33040992 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;"	08/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Crystal L Werner	Administrator	07/07/2023

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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	1. The clinical record of Resident B was reviewed on 6-19-23 at 9:45 a.m. His diagnoses included, but were not limited to congestive heart failure (CHF), atrial fibrillation, chronic obstructive pulmonary disease (COPD) and recent right lower leg skin tear. In an interview with QMA 3 on 6-19-23 at 11:32 a.m., she indicated CNA 4 had notified her of a unopened pinpoint-sized area to Resident B's right lower leg/calf area that was seeping a clear-colored liquid after dinner time on 6-10-23. QMA 3 indicated Resident B's legs tend to be reddened and swollen on a regular basis and were at that time, but were not warm to touch. She indicated the resident did not report any pain at that time and was unsure he was even aware of the issues at that time. QMA 3 indicated CNA 4 told her that she had "mentioned" the area to the Director of Nursing (DON) earlier in the day, but was unsure if the DON had an opportunity to look at the affected area prior to the DON leaving for the day. She indicated she notified the DON shortly after observing the area of the change in the resident's skin status. She indicated she was instructed by the DON to cover the area with a "Telfa" (non-adherent type of dressing) for that evening, then to remove the dressing in the morning and leave it open to air, then to re-dress the area the next afternoon. She indicated when she went to locate the dressing supplies, she did not know what a "Telfa" dressing was. She indicated she did locate a dressing labeled, "hydrocolloid bandage," which has a special type of moisture dressing with adhesive edges for securing the bandage and used this to cover the affected area for Resident B. She indicated the following morning, when she removed the dressing of Resident B, "a large amount of skin		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The DON, Corporate Nurse Consultant and Administrator reviewed all resident charts for physician notifications related to a significant change of condition and/or changes in treatments How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by the deficient practice. All resident clinical records were audited. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Administrator and DON scheduled an in-service for July 15, 2023 for all staff who have access to resident clinical records to re-educate all potential contributors to the clinical record on the expectations specific to the documentation of physician notifications for change of condition and/or changes in treatment. ul class="BulletListStyle1 SCXW33040992 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text;	

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	came off with it." She indicated she did notify Resident B's POA (power of attorney) of this incident. She indicated she does not know why she did not use a dry dressing to the skin tear area, as this would be her normal action in a similar situation. CNA 3 did not recall using any type of ointment or cream to the affected area upon redressing the area with a non-adherent dressing and gauze roll to secure the dressing. She indicated Resident B's POA arrived to the facility shortly after lunch on 6-11-23 and had Resident B transported by ambulance, related to complications with congestive heart failure and returned the same date with a different dressing to the affected area, but with no new care orders for the affected area. In a phone interview with CNA 4 on 6-19-23 at 12:25 p.m., she indicated she had observed an unopened pinpoint-sized area that was seeping a clear-colored liquid on Resident B's left lower leg on the evening of 6-8-23 at bedtime. She indicated she notified QMA 5, who she identified as being on duty that evening. She indicated she worked with the DON on 6-10-23, but did not recall addressing it with her at that time as she assumed QMA 5 had already done so two evenings prior. In an interview on 6-19-23 at 12:47 p.m., with the DON, she indicated she could not recall when she had been notified of the unopened area on Resident B's right lower leg, whether it was on 6-9-23 or 6-10-23. She recalled observing the area on one of those two days and it appeared as an unopened pinpoint area with clear drainage that she noted on a towel positioned under his right lower extremity. In observation of the nursing "as worked" schedule for June, 2023, she noted QMA 5 was not scheduled on 6-8-23. The DON indicated she did not notify Resident B's		-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" 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: The DON will audit 25% of resident charts to review all clinical record documentation monthly for 3 months and 10% monthly for 3 months. By what date the systemic changes will be completed: August 10, 2023	

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	attending physician of the unopened pinpoint-sized area with leakage to obtain care or treatment orders. A review of the nursing notes at this time with the DON indicated she did not document anything until 6-13-23, regarding "RLE [right lower extremity] wound weeping" when she notified his attending physician/clinic. A review of the nursing notes indicated on 6-10-23 at 6:30 p.m., QMA 3 documented "Observed pt [patient] with a pinpoint area on right calf, open, applied a bandaid and cream." The following morning, on 6-11-23 at 7:30 a.m., the same QMA documented, "took bandaid off and the adhesive caused his skin to peel off." An additional note 10 minutes later indicated the POA and DON were notified of this incident. The documentation failed to indicate the attending physician/clinic was notified of the incident until 6-13-23. A review of Resident B's most recent medication order listing, dated 6-11-23, from an emergency room visit. This listing indicated he had one cream, Ketoconazole 2 percent cream [an antifungal medication], one application topically daily, ordered on 1-26-23. The listing did not specify to what location or what purpose this cream was to be used for. A review of Resident B's June, 2023 Medication Administration Record (MAR) indicated he had one cream order for Ketoconazole 2 percent cream [an antifungal medication], apply topically daily. The MAR indicated it was administered daily at 8:00 a.m. The MAR did not specify to what location or what purpose this cream was used for. 2. The clinical record for Resident D was reviewed on 6-19-23 at 3:22 p.m. His diagnoses included,			

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	but were not limited to type 2 diabetes with obesity and neuropathy and Parkinson's disease. In an interview with QMA 3 on 6-19-23 at 11:32 a.m., she indicated Resident D was currently being treated for excoriation (skin redness and irritation) with an unspecified cream to the area under his abdominal folds. On 6-19-23 at 2:25 p.m., in an interview with a family member of Resident D, she indicated he was currently being treated with Nystatin powder (an antifungal medication) for a rash under his abdominal "apron" folds. She indicated this is a chronic issue for Resident D. "Between me and the aides and the nurses, we caught it early this time." A review of Resident D's nursing notes failed to indicate any documentation from 5-9-23 to exit date of 6-19-23, of any skin-related issues. A review of Resident D's physician orders for 6-9-23, indicated he currently has one antifungal medication order for Nystatin/Nystop 100,000 units/grams topical powder for one application daily, with an order date of 9-23-22. There were no "creams" identified in these orders. A review of Resident D's Medication Administration Record (MARS) for June, 2023, indicated he was administered the Nystatin/Nystop 100,000 units/grams topical powder for one application daily for "skin irritation, pruritus [itching] of skin, skin rash, eczema, treatment site sequelae." No creams were documented as being administered. On 6-19-23 at 11:00 a.m., the Administrator provided a copy of an undated policy entitled, "Resident Rights." This policy was identified as the current policy utilized by the facility. This			

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	policy indicated, "Residents have the right to have their rights recognized by the licensee...The facility must immediately consult the resident's physician and the resident's legal representative when the facility has noticed: (1) a significant decline in the resident's physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment..." This Residential tag relates to Complaint IN00410833. 2.5-1.2(k)(2)			