STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 00 B. WING	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENCROFT HEALTHCARE	1225 GREENCROFT DR GOSHEN, IN 46527

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00417491 and IN00417490. Complaint IN00417491 - No deficiencies related to the allegations are cited. Complaint IN00417490 - Federal/State deficiencies related to the allegations are cited at F686. Survey dates: September 18 & 19, 2023 Facility number: 000112 Provider number: 155205 AIM number: 100288710 Census Bed Type: SNF/NF: 156 Total: 156 Census Payor Type: Medicare: 18 Medicaid: 92 Other: 46 Total: 156 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 9/21/2023.	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-			

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

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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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop 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 observation, interview and record review, the facility failed to prevent a pressure ulcer from developing on the heel and buttock, for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: On 9/19/23 at 1:35 P.M., a review of the clinical record for Resident F was conducted. The resident's diagnoses included, but were not limited to: diabetes, anemia, arthritis, unsteadiness on feet, and a prosthetic heart valve. A Quarterly Braden Scale for Predicting Pressure Score Risk form, dated 6/16/23, indicated the resident scored a 14. The form indicated "...If the residents total is 18 or less, consider him/her at risk for pressure ulcer/injury development...." A Minimum Data Set (MDS) Significant Change assessment, dated 8/7/23, indicated the resident's cognitive status was moderately impaired, required extensive assist of 2 persons with bed mobility and toileting. In addition, was totally dependent of 2 persons with transfers. The Assessment indicated the resident weighed 127 pounds, was always incontinent of her bladder function and had acquired an unstageable	F 0686	This Plan of Correction constitutes my written statement of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Greencroft at Goshen respectfully requests a desk review. The facility is alleged to be out of compliance by failing to prevent a pressure ulcer from developing on the heel and buttock, for 1 of 3 residents reviewed for pressure ulcers. a Resident F was assessed, and care plan was updated to ensure appropriate interventions are in place. Pain was addressed at the time of the observed dressing change. Staff providing care were educated to ensure interventions are in place. b Residents with Braden	10/11/2023

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	pressure ulcer/deep tissue injury. A Care Plan, dated 12/17/19, indicated the resident was at risk for skin breakdown due to incontinence and needed help with bed mobility. On 7/3/23, Moisture-Associated Skin Damage (MASD) to the sacral area was added and on 7/26/23 Deep Tissue Injury (DTI) to heel was added to the care plan. The interventions included, but were not limited to: reposition with routine rounds, as needed, during the day when in bed or in chair, monitor skin during bathing, assess skin weekly, float heels when non-blanchable redness or softness was noted, treatments per physician orders, measure wound weekly and administer nutritional supplement, as ordered. A Progress Note, dated 7/26/23, indicated "...Resident noted to have 1.8 x 2.0 cm [centimeter] DTI to left heel...." The nurse practitioner and family were notified of the observed area. An Interdisciplinary Team (IDT) Note, dated 8/1/23, indicated resident had an area on her heel and appeared to be possible trauma from her scooter. Area was dry, callused with intact skin. The order received was to apply skin prep and facility initiated a Prevalon boot (floats the heel) for protection. A Progress Note, dated 8/3/23, indicated Active (a liquid protein supplement) was ordered for twice a day and facility provided an air alternating mattress. An IDT Note, dated 8/7/23, indicated the DTI on the left heel had the first layer of skin coming off. The wound measured 3.4 x 2.7 cm and treatment was Allyven (a layered foam dressing) was to be		scores of 18 or less were assessed for skin injury. All assessments were completed by 10/2/2023 No other issues identified. c All nursing staff will be educated on skin integrity, pain, and prevention of skin breakdown. Nurses will be educated to ensure dressings are in place. IDT will review 5Xs a week all new skin conditions, new high risk Braden scores and new and current pressure injury statuses. d An audit will be completed by the DON/Designee of wound interventions 3x/ week x4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and monthly until substantial compliance. Results will be reviewed in QA and submitted to QAPI for review.	

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	changed every 3 days. The Note indicated resident had been compliant with the heel protector boot. An IDT Note, dated 8/9/23, indicated the heel wound was now a Stage II pressure ulcer, which measured 0.8 x 2.0 x 0.4 cm. with good granulation, color-yellow. The treatment was to apply Allyven every 3 days. A Progress Note, dated 8/15/23, indicated a Nurse Aide had notified the Nurse regarding a rash, (raised clusters of pustules) between the residents breasts, along her left side and back. The Physician was notified and the resident was diagnosed with Shingles. An IDT Note, dated 8/16/23, indicated "...entered room to assess previous open area to the left heel and noted her in the recliner with out heels floated. immediately did this and assessed the wound noted previous was resolved, however this area is dark purple in color continue to monitor and continue same dressing. family and md [medical doctor] notified...." A Progress Note, dated 8/16/23, indicated a dark purple discoloration to the back of the heel further from the previous wound site, and it measured 1.0 x 1.0 cm. A Progress Note, dated 8/23/23, indicated the purple area was now pink granulation, a Stage II pressure ulcer which measured 4.0 x 2.5 x 0.3 cm. Continued with heel protector boots, air mattress and Allyven dressing every 3 days. A Progress Note, dated 8/31/23, indicated "...top layer of skin gone and yellow slough noted in center of left heel...." The Stage II pressure ulcer			

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	measured 3.0 x 2.0 x 0.1 cm. A new order was received for medihoney with boarder gauze, change every day. A Progress Note, dated 9/6/23, indicated "...top layer of skin gone and granulation with 15% yellow slough noted in center of left heel...." The Stage II pressure ulcer measured 3.0 x 2.0 x 0.1 cm. No change in the treatment. On the same day, it was documented the resident had MASD to the right upper buttock area which measured 0.1 x 0.2 cm. An IDT Note, dated 9/7/23, indicated resident had a pressure injury to her left heel with a yellow center, which measured 3.0 x 2.0 x 0.1 cm. Supplements were Active Protein twice a day and added health shakes daily. New Stage II ulcer on her left buttock which measured 2.8 x 1.7 x 0.4 cm. Treatment for the buttock wound was Allyven dressing every 3 days. The Physician had been notified and lab work was ordered. Progress Note, dated 9/14/23, indicated left heel, Stage II pressure ulcer measured 3.0 x 2.0 x 0.1 cm with pink granulation and the Stage II pressure ulcer on the coccyx measure 2.8 x 1.7 x 0.4 cm. and was slight pink with 5% slough noted in the area. No change in treatments for either wound. On 9/19/23 at 2:42 P.M., Resident F was observed in a recliner with footrest up. The resident had no pressure reducing device on her left foot. Her meal tray was in front of her. There was no cushion/pressure relieving device underneath her buttocks. The resident's bed was observed to be an air alternating bed. A Prevalon Boot was located at head of the bed. During an interview, on 9/19/23 at 3:01 P.M., CNA			

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	2 indicated the resident had been sitting, in the recliner, since before lunch and indicated lunch was served around 11:30 A.M. On 9/19/23 at 3:07 P.M., an observation of the wounds was conducted with LPN 2-Team Lead. There were no dressings covering the wounds. The left heel area had firm dark brown eschar (dead tissue within a wound) which measured 1.3 x 1.8 x 0.3 cm. The resident pulled away and said "Ouch" during the observation and reapplying of the dressing. The right side of the buttock area had a small area of MASD and the left side of the buttock there was observed an unstageable pressure ulcer which measured 1.1 x 0.7 cm. This wound had no drainage, no odor but entire area was covered with yellow slough, with no areas of granulation. On 9/19/23 at 3:40 P.M., the Assist Director of Nursing (ADON) provided a policy titled, "Pressure Injury Prevention and Management", dated 12/2019 and revised on 8/8/23, and indicated the policy was the one currently used by the facility. The policy indicated "...This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries....." This Federal tag relates to complaint IN00417490. 3.10-40(2)			