STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155576	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HARTFORD CITY SKILLED NURSING FACILITY	0548 S 100 W HARTFORD CITY, IN 47348

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 10, 11, 12, 13, and 14, 2023. Facility number: 000289 Provider number: 155576 AIM number: 100289460 Census Bed Type: SNF: 1 NF: 35 Total: 36 Census Payor Type: Medicare: 4 Medicaid: 28 Other: 4 Total: 36 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 21, 2023.	F 0000	May 5, 2023 To Indiana State Department of Health, Enclosed you will find our credible alleged compliance of our plan of correction for the survey event ID: MEIB11. We have submitted our plan of correction through the Gateway System including the plan of correction, policies, and tools as described in our plan of correction. We have set up our compliance date for May 5, 2023. We respectfully request an opportunity for paper compliance for F 686 SS=D Treatment/Services to Prevent/Heal Pressure Ulcer. Please contact us if you would like us to submit additional supporting documentation paper compliance. Respectfully Submitted, Max Richardson Administrator The Waters of Hartford City 548 South 100 West Hartford City, IN 47348	
F 0686 SS=D 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Max Richardson	Administator	05/02/2023

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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	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, record review, and interview, the facility failed to prevent the development of a pressure injury for 1 of 3 residents reviewed for pressure ulcers. (Resident 31) During an observation, on 4/10/23 at 3:55 p.m., Resident 31 was in bed, with a pressure reducing boot on his left lower extremity and a pillow under his legs. During an observation, on 4/11/23 at 9:27 a.m., the resident sat in his wheelchair in his room, with a slipper on his right foot and a pressure reducing boot on his left lower leg. and his feet on the floor. During an observation, on 4/12/23 at 11:20 a.m., the resident sat in his wheelchair in his room with a slipper on his right foot and a pressure reducing boot on his left lower leg with his feet on the floor. During an observation, on 4/13/24 at 8:16 a.m., the resident propelled himself in his wheelchair in the hallway. He wore a slipper on his right foot and a pressure reducing boot on his left lower leg. The resident's clinical record was reviewed on 4/12/23 at 2:07 p.m. His diagnoses included fracture of the left femur, weakness, muscle wasting and atrophy, polyneuropathy, and depression.	F 0686	The Waters of Hartford City respectfully submits the following plan of correction as a credible allegation of compliance to the above-mentioned regulations F-686. Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 5/5/2023. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** 1. 1. It is the policy of The Waters of Hartford City to prevent the development of a pressure ulcers. 2. 2. The care plan and interventions for Resident #31 have been reviewed and updated. 3. 3. All residents have the potential to be affected. The	05/05/2023

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	His current physician's orders included cleanse open blister to back of left heel, apply petrolatum gauze, cover with 4x4 gauze and secure with wrap gauze daily until healed (3/16/23), monitor open blister to back of left heel every shift until healed (3/16/23), pressure reducing boot to left foot at all times every shift (3/28/23), and use mechanical lift for transfers (2/9/23). A 2/14/23 5-day MDS (Minimum Data Set) assessment indicated the resident was moderately cognitively impaired, required extensive assistance for bed mobility, dressing, and toileting, was totally dependent on the assistance of two persons for transfers, and had a recent surgery for repair of a fractured hip. A current skin risk care plan, initiated 1/6/23, indicated as a goal, the resident would be provided with preventative measures in an attempt to avoid skin breakdown (revised 1/16/23). Interventions included float heels while in bed (1/6/23), lay down for rest during the day (2/28/23), monitor skin daily during care (1/6/23), remind or assist to turn at least every two hours (2/28/23), and skin assessment at least weekly by nurse (2/28/23). A wound care plan, initiated on 3/15/23 and revised on 4/11/23, indicated the resident had developed an actual pressure injury, an unstageable area to the left heel which had become a stage three pressure injury (full thickness tissue loss) on 4/11/23. Interventions included float heels off the bed (3/15/23), leave shoes off feet at this time (initiated 3/15/23, with revision 3/17/23), and pressure reducing boot to left lower extremity at all times (3/28/23).		facility has reviewed all resident's skin and no other residents were found with any skin issues. The facility has also reviewed all footwear to ensure proper fit and no issues were found. Facility reviewed preventive interventions and care plans updated accordingly. 4. 4. The DON and ADON educated all nursing staff regarding ensuring proper fit of shoes, as well as ensuring interventions are in place to prevent pressure ulcers. Any staff that fail to comply with the points of the in-service will be further educated and/or progressively disciplined as necessary. In-service was completed 4/26/23 see attendance log (Attachment A). 5. 5. To ensure that this deficient practice does not re-occur the Quality Improvement Audit Tool "Pressure Prevention" (Attachment B) will be completed by the DON or designee for all residents with moderate / high risk for pressure ulcers. DON or designee will audit 10 residents for pressure ulcer interventions weekly x 4 weeks, then 5 residents weekly x 4 weeks, then 5 residents monthly x 4 months. The monitoring will take place for no less than 6 months. If the facility is within 100% compliance at the end of 6 months monitoring will be stopped. At the monthly	

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	A General Note, dated 3/15/23 at 11:15 p.m., indicated the resident had a popped blister on the left heel. The area was cleaned, and a bandage was applied. A Physician's Order Note, dated 3/16/23 at 11:36 p.m., indicated a new physician's order had been received to cleanse the open blister to the back of the left heel, apply petrolatum gauze, cover with a 4x4 gauze and secure with wrap gauze every day shift until healed and as needed for soilage or dislodgement. A Weekly Wound Evaluation, dated 3/16/23 at 11:36 a.m., indicated a new pressure injury to the back of the left heel was identified on 3/15/23. The pressure injury was acquired in the facility. The pressure injury was a stage two (partial thickness skin loss with exposed dermis) and measured 4.0 centimeters (cm) long by 3.0 cm wide by less than 0.1 cm deep. The wound color was red. The wound was comprised of 10% granulation (new connective tissue with microscopic blood vessels) tissue visible with skin covering the rest of the wound. A Weekly Wound Evaluation, dated 3/21/23 at 1:58 p.m., indicated the pressure injury to the back of the left heel was a stage two, and measured 2.0 cm long by 1.5 cm wide by less than 0.1 cm deep. The wound color was red with 100% granulation tissue present and visible. A Weekly Wound Evaluation, dated 3/28/23 at 2:01 p.m., indicated the pressure injury to the back of the left heel was unstageable (obscured full thickness skin and tissue loss) and measured 2.0 cm long by 1.5 cm wide and less than 0.1 cm deep. The wound color was red with 5% granulation, 5% slough (dead tissue usually yellow or cream in		QAPI meeting, the monitoring of the audit be reviewed. Any concerns will have been corrected as found, then logged on the Quality Improvement Summary Log (Attachment C). Any patterns will be identified. If necessary, an Action Plan will be written by the committee, any action plan will be monitored by the Administrator weekly until resolution is met. 6. 6. All Systemic changes will be in place by 5/5/2023	

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	color), and 90% necrotic tissue. Most of the wound was covered with thick eschar (dry, black, hard necrotic tissue) with open surrounding edges comprised of yellow slough and red granulation tissue. A General Note, dated 3/28/23 at 2:13 p.m., indicated the physician was updated on the status of skin breakdown. A new order for a pressure reducing boot to the left lower extremity at all times was received. A Weekly Wound Evaluation, dated 4/11/23 at 11:46 a.m., indicated the pressure injury to the back of the left heel was a stage three and measured 2.0 cm long by 1.5 cm wide by less than 0.1 cm deep. The wound bed was covered with 50% yellow, moist slough and 50% pink, moist tissue. During an observation, on 4/13/23 at 10:21 a.m., RN 3 removed the dressing from the resident's left foot. The pressure injury on the back of the left heel was approximately the size of a quarter, with a pink wound bed and a black area in the center. The black area was approximately the length of two quarter edges and the width of the diameter of a nickel. The depth of the wound was approximately the edge of a quarter. In an interview during the observation, RN 3 indicated an eschar cap on the pressure injury had come off recently. She was uncertain of the date. During an interview, on 4/13/23 at 3:08 p.m., CNA 4 indicated the resident was unable to put on shoes himself since he fractured his hip. He used a mechanical lift and was unable to scoot himself up on his own. During an interview, on 4/13/23 at 3:37 p.m., the			

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	ADON indicated the blister on the back of the left heel was where his shoe had rubbed. He had hard leather heavy-duty shoes. During an interview, on 4/14/23 at 11:40 a.m., CNA 5 indicated the resident was unable to apply his shoes or socks, though he could kick off his footwear. During an interview, on 4/14/23 at 11:51 a.m., the ADON indicated the resident propelled himself in the wheelchair and might have rubbed his heel prior to developing the blister to his left heel. During an interview, on 4/14/23 at 12:24 p.m., the ADON indicated after the blister was found on the resident's heel, he continued to have the staff put on his shoes even though she kept reminding him to not wear his shoes. An undated facility policy, provided by the DON on 4/14/23 at 11:53 a.m., titled "Preventative Skin Care," indicated "Guideline: It is the intent of the facility that the facility provide preventive skin care through careful washing, rinsing, and drying to keep residents clean, comfortable, well-groomed, and free from pressure sores ...Ensure proper fit of wheelchairs, braces, shoes, and prosthetic devices ...." 3.1-40(a)(1)			