STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00444009. Complaint IN00444009 - Federal/state deficiencies related to the allegation are cited at F686. Survey dates: December 20, 2024 Facility number: 000359 Provider number: 155566 AIM number: 100274920 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 1 Medicaid: 45 Other: 11 Total: 57 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 12/27/2024	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective January 19, 2025 for the complaint survey completed December 20, 2024. The facility requests paper compliance in lieu of a revisit.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review and interview, the facility failed to provide appropriate interventions to prevent the development of pressures ulcers for 1 of 2 residents reviewed for pressure ulcers (Resident B). Finding includes:	F 0686	F 686 Treatments to Prevent/Heal Pressure Ulcers It is the practice of this facility to ensure that residents receive care consistent with professional standards of practice to prevent pressure ulcers and to not develop	01/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan A Jackson, HFA	Administrator	01/10/2025

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	A record review for Resident B was completed on 12/20/2024 at 12:45 P.M. Diagnoses included, but were not limited to: peripheral vascular disease, diabetes mellitus type 2, heart failure and lymphedema. A Braden Scale (assessment to determine a resident's risk for developing pressure ulcers) assessment, completed on 8/21/2024, indicated Resident B was at risk for skin breakdown. A Braden Scale assessment, completed on 9/24/2024. indicated Resident B was at a moderate risk for skin breakdown. A Quarterly Minimum Data Set (MDS) assessment, dated 10/2/2024, indicated Resident B was cognitively intact, required substantial/maximum assistance for bed mobility and transfers, was dependent on shower assistance, was at risk for developing pressure ulcers, had a stage 3 pressure ulcer and diabetic foot ulcers. The assessment indicated the resident utilized a pressure-reducing device for his bed and nutrition/hydration interventions were utilized to manage his skin problems. The assessment indicated the resident had not had any behaviors of rejection of care during hte assessment time frames. A care plan, initiated 5/12/2023 and revised on 4/18/2024, indicated Resident B had the potential for pressure ulcer development or skin breakdown related to immobility, incontinence and seborrhea dermatitis. The goal was for the resident to have no skin breakdown. Interventions included, but were not limited to: encourage not to sit up in wheelchair for prolonged periods of time, pressure relief mattress on bed and assist with turning and repositioning as needed.		pressure ulcers. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficiency practice:** The medical record for Resident B has been reviewed to ensure appropriate interventions to prevent the development of pressure ulcers are in place. A low air loss mattress was recommended but resident refused placement. A task was placed on the EMR to check for stool incontinence and change brief as indicated. Dietary interventions were reviewed by the dietician in the nutrition at risk meeting and a recommendation made per resident preference. **How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents at risk for pressure injuries have the potential to be affected by the alleged deficient practice. An audit will be completed to identify residents at risk for the development of pressure ulcers to ensure appropriate interventions are in place. A skin sweep was performed on all residents with no additional pressure injuries identified. **What measures will be put into place and what systemic**	

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	A care plan titled, ADL (activities of daily living) Self Performance, initiated on 5/12/2023 and revised on 8/25/2024 indicated the resident had deficits related to mobility and incontinence. The interventions, included but were not limited to: Hoyer (mechanical) lift and two assist to transfer to bedside commode. A Weekly Skin Review, dated 11/11/2024 at 10:42 A.M., indicated Resident B's skin was intact. The assessment indicated Resident B had chronic leg and foot wounds, redness to the scrotum with an order for in-house Triad Hydrophilic (a zinc oxide-based paste to facilitate autolytic debridement) paste for incontinence. Resident B was marked as having no new skin issues. However, a Physician's Consultation Note from the wound clinic, dated 11/11/2024, indicated Resident B had complained of a buttock pressure wound that had been present for at least one week. There was no current ordered treatment for the pressure ulcer. A left gluteal ulceration was observed that measured 0.6 centimeters by 1.2 centimeters by 0.1 centimeters. The base was covered in yellow slough and the physician deemed the ulcer, a stage 3 pressure ulcer. In addition, a stage 2 pressure ulceration was noted left of the resident's coccyx, measuring 2 centimeters by 1 centimeter by 0.1 centimeters. The wound base of this ulcer was pink and yellow. There was also a superficial, unstageable wound noted to the left ischial area (the lower and back part of the hip bone). The ulceration measured 0.4 centimeters by 0.4 centimeters. New orders were provided for treatment of the new pressure ulcers. A Nursing Progress Note, dated 11/11/2024 at 2:00		**changes will be made to ensure the deficient practice does not recur:** Clinical staff will be re-educated on the Skin and Wound Management System policy, including but not limited to assessment and implementation of interventions for residents at risk for the development of pressure ulcers. Clinical alerts for skin conditions will be reviewed in each morning clinical meeting to identify new pressure injuries and interventions added as appropriate **How the corrective actions will be monitored to ensure the deficient practice does not recur:** The Director of Nursing or designee will conduct a random audit of Braden assessments to ensure appropriate interventions are in place for residents at risk for the development of pressure ulcers 5 times a week for 4 weeks, 1 time a week for 4 weeks and monthly for 4 months. Audit results will be forwarded to the QA&A Committee for review and disposition. **By what date the systemic changes will be made:** January 19, 2025	

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	P.M., indicated Resident B had returned from the Wound Clinic and had 3 new pressure areas noted to the left gluteal, coccyx and left ischium areas. A Weekly Pressure Injury Evaluation, completed on 11/11/2024 at 3:19, 3:21 and 3:23 P.M. indicated the following: Resident B had an in-house acquired stage 3 left gluteal ulceration, measuring 0.6 centimeters by 1.2 centimeters by 0.1 centimeters with an onset date of 11/11/2024, an in-house acquired stage 2 pressure ulcer of the coccyx. The pressure ulcer measured 2 centimeters by 1 centimeter by 0.1 centimeter and an in-house acquired stage 2 pressure ulcer of the left ischium. The pressure ulcer measured 0.4 centimeters by 0.4 centimeters. The evaluation indicated pressure relieving devices were in place, which included a low air loss mattress. A Care Plans, initiated on 11/12/2024, indicated Resident B had pressure ulcer development related to a history of ulcers and immobility to the left gluteal, coccyx and ischium. The goal was for Resident B to show signs of healing and to remain free from infection. Interventions included, but were not limited to: administer medications as ordered, administer treatments as ordered and monitor for effectiveness and to assess/record/monitor wound healing by measuring length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress and report improvements and declines to the physician A Physician's Order, dated 11/12/2024, indicated Triad Hydrophilic Wound Cream External Paste was to be applied to left gluteal and ischial wounds every shift and as needed.			

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	A Nutrition at Risk/Interdisciplinary Note, dated 11/14/2024 at 4:19 P.M., indicated there were no updates on skin integrity as wounds were managed by the wound clinic. There were no new nutritional interventions implemented to address the resident's new pressure ulcer development. The physician's orders related to nutritional needs for Resident B, prior the new pressure area developments were regular diet with double portions at breakfast and double protein portions at lunch and dinner, dated 5/12/2023 and Glucerna 1.2 (nutritional supplement drink) two time a day, ordered on 12/10/2023. There was also a physician's order, dated 5/10/2023 for the registered dietician to evaluate for nutritional interventions if needed. The only interventions implemented after Resident B's pressure ulcer development was the treatment ordered by the wound clinic for Triad cream and a low air loss mattress. However, per observation, on 12/20/2024 at 1:01 P.M., a low air loss mattress was not in place on Resident B's bed and there was no documentation of the resident refusing the intervention. Weekly Pressure Injury Evaluation reports, completed on 11/18/2024, indicated there was a stage 3 left gluteal pressure ulcer which measured 0.5 centimeters by 1.4 centimeters by 0.2 centimeters, a stage 2 pressure ulcer to the left ischium which measured 0.3 centimeters by 0.4 centimeters and a stage 2 pressure ulcer to the coccyx measured 1.7 centimeters by 0.7 centimeters by 0.1 centimeters. The current treatment for the wounds included Triad paste. A Physician Consultation Note from the wound clinic, dated 11/27/2024, indicated Resident B had been seen for chronic diabetic foot ulcers and a			

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	left buttock pressure ulceration that had been present since 11/11/2024. Resident B had reported the dressings were not being changed routinely and the nursing home staff were not following the physician orders. Resident B presented to the physician's office with a new coccygeal ulceration. The left gluteal ulceration measured 0.4 centimeters by 1.3 centimeters by 0.1 centimeters. The wound base was yellow and gray. The peri wound skin was dusky. The wound was consistent with a stage 3 pressure ulceration at a minimum due to the presence of the yellow slough. The ulceration to the left of the coccyx measured 1.6 centimeters by 0.5 centimeters by 0.1 centimeters. The base was yellow and gray with the peri wound dusky. A new non-blanchable wound was noted just to the right of the coccyx and measured 0.5 centimeters by 0.2 centimeters. The wound was consistent with a suspected deep tissue injury. The ischium pressure ulcer was epithelized. A Physician Consultation Note from the wound clinic, dated 12/5/2024, indicated Resident B presented with a worsening left gluteal ulceration. Resident B was incontinent of stool upon his arrival to the appointment. Resident B reported to the physician that his incontinence brief only got changed in the evening and the nighttime but not at all during the day. The gluteal ulceration measured 0.7 centimeters by 1.3 centimeters by 0.1 centimeters. The base was black. The left coccyx wound measured 1.4 centimeters by 0.7 centimeters by 0.1 centimeters. The base was yellow and gray. The non-blanchable redness to the right of the coccyx was resolved. The pressure ulcer of the left buttock had worsened from the prior week and was suspected the worsening was due to contamination of the wound with stool most of the time. The Triad cream was			

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	discontinued, and gentamicin (an antibiotic) ointment was ordered to be applied to the wound, three times a day. A Physician's Order, dated 12/6/2024, indicated gentamicin sulfate 0.1 percent cream apply to coccyx wound topically three times a day for wound care. A Physician's Consultation Note from the wound clinic, dated 12/12/2024, indicated Resident B presented to the office with a large amount of dry stool in his incontinence brief. Resident B indicated his brief had not been changed from the time he had gotten up in the morning. He indicated it usually did not get changed until he went to bed late at night. Resident B reported the gentamicin ointment was not being applied to his coccygeal and buttock ulcerations three times a day as ordered. The left gluteal ulceration measured 0.6 centimeters by 1.2 centimeters by 0.1 centimeters. The pressure ulceration to the left of the coccyx measured 1.2 centimeters by 0.4 centimeters by 0.1 centimeters. The pressure ulcer to the left buttock had minimal improvement from the last visit and was likely due to the nonadherence with treatment plan and incontinence of feces. The physician recommended that Resident B be checked for incontinence of stool every 2 hours as the ulcers were likely contaminated with stool frequently which would delay wound healing and could likely cause worsening of the ulcerations. There was no documentation the wound clinic recommendation to check the resident frequently, every two hours for stool incontinence was implemented, no new nutritional interventions were implemented and no new pressure relieving interventions were implemented due to the			

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	worsening of the resident's pressure ulcers. During an observation, on 12/20/2024 at 1:01 P.M., Resident B was observed to have a traditional foam pressure relieving mattress on his bed and a pressure relieving device (cushion) in his wheelchair. There was no air loss mattress on Resident B's bed. During an interview with Resident B, on 12/20/2024 at 1:41 P.M., he indicated his last incontinence change had been at 4:00 A.M. Resident B declined a request to observe his brief for incontinence. During an interview, on 12/20/2024 at 3:02 P.M., LPN 2 indicated she when she had completed the skin assessment on 11/11/2024, she had not actually visually assessed Resident B's buttock. She indicated when a resident received a shower, the CNA would provide a shower sheet that indicated if a new skin issue had been observed. LPN 2 indicated she would assess a resident's skin condition based upon the shower sheet information. She indicated Resident B sat in his wheelchair all day and did not lay down. She indicated Resident B was incontinent of his bowel and bladder at times. LPN 2 indicated nurses should apply the treatment cream to Resident B's buttock, but she had left the cream at the bedside for the CNAs to apply and she could not confirm if the cream had actually been applied as ordered LPN 2 indicated Resident B could not change positions in the wheelchair independently, but he might be able to scoot himself some in the wheelchair seat. During an interview on 12/20/2024 at 3:10 P.M., QMA 3 indicated a shower sheet was utilized and any skin conditions was to be communicated to			

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	the nurse. QMA 3 indicated Resident B utilized a shower chair when showered and an observation of Resident B's buttock and skin condition should have been reported to the nurse on the shower sheet. She indicated incontinent care was provided when Resident B asked for assistance and he was incontinent of his bowel and bladder. She indicated he was not routinely checked for stool incontinence and had no toileting plan. During an interview on 12/20/2024 at 3:08 P.M., the Medical Records Coordinator indicated the only shower sheets that were kept for records were the shower sheets with resident refusals of showers. The shower sheet for 11/11/2024 was not available for Resident B. During an interview, on 12/20/2024 3:22 P.M., CNA 4 indicated she has showered Resident B and he was dependent on showering assistance. She indicated shower sheets were utilized to communicate any skin issues noted on a resident during a shower. A policy was provided by the Executive Director, on 12/20/2024 at 4:20 P.M. The policy, titled, "Skin and Wound Management System", indicated, " ...It is the policy of this center's Skin Management System to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcomes ...3. Ongoing weekly evaluations of resident's skin will be completed and documented [in the facilities electronic medical record] on the 'Weekly Skin Evaluation' form ...4. Preventative intervention will be implemented for residents identified at risk as			

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	appropriate ...5. Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection ...." This Federal tag relates to complaint IN00444009. 3.1-40(a)(1)			