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	155200	A. BUILDING _____ B. WING _____	C 02/25/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00452449 and IN00452401. Complaint IN00452449 - No deficiencies related to the allegations are cited. Complaint IN00452401 - Federal/state deficiencies related to the allegations are cited at F684 and F686. Survey dates: February 21, 24, and 25, 2025 Facility number: 000107 Provider number: 155200 AIM number: 100290330 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 3 Medicaid: 54 Other: 8 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 5, 2025.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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	F 684		

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

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F 684	Continued From page 1 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify and implement interventions for care of a surgical wound for 1 of 3 resident reviewed for wound care. (Resident B) The deficient practice was corrected on February 10, 2025, prior to the start of the survey, and was therefore past noncompliance. Findings include: Resident B's closed clinical record was reviewed on 2/25/25 at 1:26 p.m. Diagnoses included fracture of neck of right femur, subsequent encounter for closed fracture with routine healing, acute posthemorrhagic anemia, and dementia with other behavioral disturbance. The resident admitted to the facility on 12/30/24 following surgical repair of the right femur fracture (on 12/24/24) and obstructive and reflux uropathy (urinary obstruction). A care plan, dated 12/31/24, indicated Resident B was a new admission to the facility and required implementation of services to promote physical, emotional, and psychosocial well-being including assistance with activities of daily living related to chronic obstructive pulmonary disease, weakness, right femur fracture with immobilizer. Interventions included an intervention to provide special treatments or devices.	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 2	F 684		

A care plan, dated 12/31/24, indicated Resident B was at risk for skin breakdown due to weakness, incontinence and right leg immobilizer. Interventions included assess and document skin condition weekly and as needed.

A care plan, dated 12/31/24, indicated the resident was at risk for falls due to weakness, history of falls, advanced age, medications, tethering equipment, incontinence, impaired cognition, and right leg immobilizer.

A care plan, dated 1/8/25, indicated the resident had impaired skin (surgical). Interventions included assessing wounds weekly and documenting measurements and description. Notify MD of change in wound such as worsening or signs of infection. Wound location: right hip. Observe for sings of infection: redness, pain, drainage, malodorous drainage, fever, increase in size/depth of wound.

Review of the 12/30/24 admission assessment indicated Resident B presented with a dressing to the right thigh and a right leg immobilizer. An assessment of the skin under the immobilizer was not completed.

Review of a progress note, dated 12/31/24 at 2:12 a.m., indicated Resident B had a brace to the right leg in place. The resident's skin was not assessed.

Review of the progress notes from 12/20/24 through 1/3/2025 indicated the surgical wound was assessed, but the dressing to the surgical wound was not removed.

Review of a Skin and Wound note by the Wound

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F 684	Continued From page 3	F 684		

Nurse Practitioner (NP), dated 1/3/25 at 11:38 a.m., indicated a dressing to the right hip/thigh surgical area was in place and was to be left in place until the resident was seen by the surgeon. The dressing was not removed.

Review of a progress note, dated 1/3/25 at 2:30 p.m., indicated the resident required assistance of two people for all activities of daily living and tolerated the use of assistive devices.

The most recent admission Minimum Data Set (MDS) assessment, dated 1/6/25, indicated Resident B was at risk for pressure injuries and had impairment to one side on the lower extremity. The resident required partial/moderate assistance for eating, oral hygiene, upper body dressing, roll left to right. Substantial/max assistance for personal hygiene, sit to stand, lying to sitting, picking up an object. He was dependent for toilet/shower transfer, sit- to-stand, footwear application and removal, dressing lower body, showers, and toilet hygiene. He was incontinent of bowel and admitted with an indwelling catheter.

An orthopedic surgeon progress note, dated 1/14/25, indicated Resident B's right leg surgical site had the staples removed and steri-strips were placed.

Resident B's physician orders, Medication Administration Records (MAR), and Treatment Administration Records (TAR) for 12/30/24 through 1/17/25 lacked orders for care of the resident's surgical site.

Resident B transferred to another long-term care facility on 2/17/25 per their choice.

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During a phone interview on 2/24/25 at 10:25 a.m., the orthopedic surgeon's nurse indicated the surgeon's office note from the hospital indicated the dressing to Resident B's right leg surgical site should have been changed five days following the surgery.

During an interview on 2/24/25 at 11:13 a.m., LPN 1 indicated Resident B admitted to the facility with a right leg immobilizer brace in place and a surgical wound to the right thigh. No orders for an immobilizer nor for surgical wound care were in place at admission to the facility. LPN 1 did not call to get clarification for the missing orders. Residents were to have weekly skin assessments completed and documented in the clinical record. LPN 1 was unable to locate skin assessments completed for Resident B in the clinical record since his admission to the facility on 12/30/24.

During an interview on 2/24/25 at 12:01 p.m., the DON indicated, during the NP's surgical wound assessment of Resident B, the dressing was not removed. The NP recommended the dressing to stay in place until the resident was seen by the surgeon. The DON indicated she thought she had called the surgeon's office for order clarification, but she may have confused the resident with another who had similar care needs. The DON could not indicate why weekly skin assessments were not completed for Resident B.

During an interview on 2/24/25 at 1:52 p.m., the Wound Nurse Practitioner (NP) indicated surgeons usually did not want anyone to remove a surgical dressing until the first follow-up visit. She did not have the authority to write orders in the facility. The facility should have gotten a clarification from the surgeon.

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F 684	Continued From page 5 A current facility policy, dated 7/24, titled "Admission/Return Admission Policy Procedure" was provided by the DON on 2/25/25 at 1:57 p.m. The policy indicated the following: "Policy: It is the policy of American Senior Communities to provide baseline and accurate documentation of the mental, physical condition of each resident admitted or readmitted to the facility and to assist the resident and family with adjusting to the facility. Admission procedures will be followed for all new admissions including respite care. .... Initial nursing assessment: Admission Observation .... 5. A thorough head to toe assessment (including skin) must be done at admission. Any altercations in skin integrity must be identified on nursing assessment. The physician must be notified for specific treatment orders. .... Physician orders: .... Verification of orders: 1. The admitting nurse must call the attending physician to verify all orders upon admission. ...." A current facility policy, dated 7/24, titled "Documentation Guidelines for Nursing: was provided by the DON on 2/25/25 at 1:57 p.m. The policy indicated the following: " .... Resident Assessments Completed Weekly Weekly skin and vital signs assessment observation (All new skin areas must be reported to the wound nurse with new skin event completed) ...." Review of Resident B's progress notes and assessments in the clinical record lacked weekly skin assessments.	F 684		

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F 684	Continued From page 6 During an interview on 2/24/25 at 2:07 p.m., the DON and the Corporate Consultant indicated the facility should have noted the lack of orders related to the surgical wound and the leg immobilizer. This deficient practice was corrected by February 10, 2025 after the facility implemented a systemic plan that included the following actions: assessment of all residents for wounds, in-servicing education to staff related to completion of skin assessments and clarification of or obtaining treatment orders, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI) activities. This citation relates to Complaint IN00452401. 3.1-(37)(a)	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §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 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. This REQUIREMENT is not met as evidenced by:	F 686		

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F 686	Continued From page 7 Based on interview and record review, the facility failed to implement skin assessments to identify pressure injury, failed to obtain orders for a medical device that increased the risk of skin impairment, and failed to develop and implement interventions to prevent pressure injury for 1 of 3 residents reviewed for pressure injury. (Resident B) This deficient practice resulted in Resident B developing an unstageable pressure injury to the right knee requiring hospitalization and eventual amputation of the lower leg. The deficient practice was corrected on February 10, 2025, prior to the start of the survey, and was therefore past noncompliance. Findings include: Resident B's closed clinical record was reviewed on 2/25/25 at 1:26 p.m. Diagnoses included fracture of neck of right femur, subsequent encounter for closed fracture with routine healing, acute posthemorrhagic anemia, and dementia with other behavioral disturbance. The resident admitted to the facility on 12/30/24 following surgical repair of the right femur fracture and obstructive and reflux uropathy (urinary obstruction). A care plan, dated 12/31/24, indicated Resident B was at risk for skin breakdown due to weakness, incontinence and right leg immobilizer. Interventions included assess and document skin condition weekly and as needed. A care plan, dated 12/31/24, indicated the resident was at risk for falls due to weakness, history of falls, advanced age, medications, tethering equipment, incontinence, impaired	F 686	Past noncompliance: no plan of correction required.	

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cognition, and right leg immobilizer.

Review of the 12/30/24 admission assessment indicated Resident B presented with a dressing to the right thigh and a right leg immobilizer. An assessment of the skin under the immobilizer was not completed.

Review of a progress note, dated 12/31/24 at 2:12 a.m., indicated Resident B had a brace to the right leg in place. The resident's skin was not assessed.

Review of a Skin and Wound note by the Wound Nurse Practitioner, dated 1/3/25 at 11:38 a.m., indicated the resident admitted with a right heel deep tissue injury (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) and skin tears to the right elbow and left upper forearm. A dressing to the right hip/thigh surgical area was in place and was to be left in place until resident was seen by the surgeon.

The care plan lacked interventions to support healing of the right heel deep tissue injury.

The care plan lacked interventions specific to the management of the leg immobilizer, including prevention of pressure injury.

Review of a progress note, dated 1/3/25 at 2:30 p.m., indicated the resident required assistance of two people for all activities of daily living and tolerated the use of assistive devices.

The most recent admission Minimum Data Set (MDS) assessment, dated 1/6/25, indicated

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Resident B was at risk for pressure injuries and had impairment to one side on the lower extremity. The resident required partial/moderate assistance for eating, oral hygiene, upper body dressing, roll left to right. Substantial/max assistance for personal hygiene, sit to stand, lying to sitting, picking up an object. He was dependent for toilet/shower transfer, sit- to-stand, footwear application and removal, dressing lower body, showers, and toilet hygiene. He was incontinent of bowel and admitted with an indwelling catheter.

An orthopedic surgeon progress note, dated 1/14/25, indicated a necrotic (dead tissue) wound was identified on the resident's right knee, which may have had full-thickness involvement. A petrolatum (for wound care) dressing was applied to the knee wound and its use was added to the plan of care. The wound required monitoring by a wound care provider. An absorbent dressing to the right knee was to be managed by the wound care provider. There was concern about the pressure injury to the right knee and treatment was aimed at healing.

An order written by the orthopedic surgeon, dated 1/14/25 during a follow up appointment indicated wound care to the open area on the right knee was to start on 1/17/25.

An "event" progress note, dated 1/17/25, indicated an open area (wound) measuring 4.0 centimeters (cm) long by 3.0 cm wide on the right knee was identified on 1/14/25.

Resident B's physician orders, Medication Administration Records (MAR), and Treatment Administration Records (TAR) for 1/14/25 through 1/17/25 lacked orders for right knee wound care

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until 1/17/25.

Resident B transferred to another long-term care facility on 2/17/25 per their choice.

A wound management note from the receiving long term care facility indicated Resident B presented with an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure injury to the right knee, measuring 2.0 cm long with a depth of 0.5 cm. The width could not be accurately measured. The wound was covered with slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) and eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like).

An orthopedic hospital consultation note, dated 1/29/25, indicated Resident B presented on 1/28/25 with a necrotic wound on the right knee. The wound was identified during an orthopedic follow-up appointment on 1/14/2025 and had developed purulent drainage and then visible bone and hardware (from previous knee replacement). The resident underwent right leg above-the-knee amputation on 1/29/25.

During a phone interview on 2/24/25 at 10:25 a.m., the orthopedic surgeon's nurse indicated the surgeon's office note from the hospital to another hospital following surgery (no date provided) did not include the use of an immobilizer brace to Resident B's right leg.

During an interview on 2/24/25 at 11:13 a.m., LPN

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1 indicated Resident B admitted to the facility with a right leg immobilizer brace in place. No orders for an immobilizer were in place at admission to the facility. LPN 1 did not call to get clarification for the missing order for the immobilizer in place to Resident B's right leg. Residents were to have weekly skin assessments completed and documented in the clinical record. LPN 1 was unable to locate skin assessments completed for Resident B in the clinical record since his admission to the facility on 12/30/24.

During an interview on 2/24/25 at 11:30 a.m., Physical Therapist (PT) 2 indicated Resident B was on therapy caseload. The resident admitted to the facility with a right leg immobilizer. The immobilizer needed to be adjusted on occasion due to it slipping out of place. PT 2 was not sure but believed the admission orders included non-weight bearing status and a right leg immobilizer.

During an interview on 2/24/25 at 12:01 p.m., the DON indicated Resident B's clinical record lacked an order for the use of a right leg immobilizer. The DON thought she had called for clarification but had no documentation of the call. She may have confused two similar residents who admitted around the same time. LPN 1 should have caught the lack of orders for the leg immobilizer and clarification should have been completed and documented.

During an interview with CNA 3 and 1 on 2/24/25 at 1:00 p.m., CNA 3 indicated Resident B had a brace on his right leg from his thigh to his ankle during his stay. It had been removed during sleep and for showers. CNA 1 indicated they had given the resident a shower once during their stay

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and did not notice any new skin impairments. A shower sheet, dated 1/12/25, indicated CNA 3 did not find any new skin impairments.

During an interview on 2/24/25 at 1:52 p.m., the Wound Nurse Practitioner (NP) indicated surgeons usually did not want anyone to remove a surgical dressing until the first follow-up visit. She did not have the authority to write orders in the facility. The facility should have gotten a clarification from the surgeon.

A current policy, dated 7/24, titled "Admission/Return Admission Policy Procedure" was provided by the DON on 2/25/25 at 1:57 p.m. The policy indicated the following:
"Policy: It is the policy of American Senior Communities to provide baseline and accurate documentation of the mental, physical condition of each resident admitted or readmitted to the facility and to assist the resident and family with adjusting to the facility. Admission procedures will be followed for all new admissions including respite care. ....
Initial nursing assessment: Admission Observation ....
5. A thorough head to toe assessment (including skin) must be done at admission. Any altercations in skin integrity must be identified on nursing assessment. The physician must be notified for specific treatment orders. ....
Physician orders: ....
Verification of orders:
1. The admitting nurse must call the attending physician to verify all orders upon admission. ...."

A current policy, dated 7/24, titled "Documentation Guidelines for Nursing: was provided by the DON on 2/25/25 at 1:57 p.m.

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UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 686	Continued From page 13 The policy indicated the following: " .... Resident Assessments Completed Weekly skin and vital signs assessment observation (All new skin areas must be reported to the wound nurse with new skin event completed) ...." Review of Resident B's progress notes and assessments in the clinical record lacked weekly skin assessments. During an interview on 2/24/25 at 2:07 p.m., the DON and the Corporate Consultant indicated the facility should have noted the lack of orders related to the surgical wound and the leg immobilizer. This deficient practice was corrected by February 10, 2025 after the facility implemented a systemic plan that included the following actions: assessment of all residents for pressure injuries, in-servicing education to staff related to completion of skin assessments and clarification of or obtaining treatment orders, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI) activities. This citation relates to Complaint IN00452401. 3.1-40 (a)(1)	F 686		