STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155798	A. BUILDING 00 B. WING	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00421612, IN00421620, and IN00421741. Complaint IN00421612 - Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00421620 - No deficiencies related to the allegation are cited. Complaint IN00421741 - Federal/state deficiencies related to the allegations are cited at F609. Survey dates: November 16 and 17, 2023 Facility number: 012861 Provider number: 155798 AIM number: 201080610 Census Bed Type: SNF/NF: 84 SNF: 25 Total: 109 Census Payor Type: Medicare: 30 Medicaid: 58 Other: 21 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 20, 2023.	F 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is provided as evidence of the facilities desire to comply with regulations and continue to provide quality care. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jaime Sevier	RN	11/30/2023

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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	abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to report timely, a suspicious injury of unknown source for 1 of 3 residents reviewed (Resident N). Findings include: An Indiana Report, dated 11/12/23 at 11:52 a.m., indicated Resident N had been found with discoloration around her left eye and both wrists.	F 0609	Resident N was reassessed by the Director of Nursing Services and facility Wound Nurse to verify the location and extent of injury. The Physician and the resident's son were notified promptly upon completion of the assessment. Investigation was initiated and completed by the Director of Nursing Services and the facility	12/07/2023

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	A head to toe assessment was completed and no other injuries were observed. The resident denied pain and when asked, indicated she hadn't known how the injuries occurred. On 11/16/23 at 9:33 A.M., Resident N was observed seated in her room in a wheelchair with an overbed table positioned in front of her. She had a puffy black bruise below her left eye and dark discoloration around her right earlobe. She hadn't responded when asked how the bruise to her face occurred or when questioned if she had fallen. On 11/16/23 at 9:35 A.M., Resident N's roommate, identified as interviewable, was interviewed. The roommate indicated the night the injuries occurred, she hadn't heard the resident yell, raised voices or a scuffle behind the privacy curtain. On 11/16/23 at 10:09 A.M., Resident N's record was reviewed. Diagnoses included vascular dementia, anxiety disorder, rheumatoid arthritis, and weakness. A quarterly MDS (Minimum Data Assessment) dated 10/11/23, indicated the resident had severely impaired cognition, had some difficulty with hearing in noisy environments, and wore glasses. She was dependent on staff for transfers, lower body dressing, and bed mobility. She required maximal assistance with toileting and personal hygiene and was always incontinent of bowel and bladder. A care plan, revised on 11/16/23, indicated the resident was on a behavior management program due to a diagnosis of psychosis and had fluctuations in her mood. She had behavioral symptoms of yelling and screaming at staff, trying		Administrator. The facility has determined that all residents have the potential to be affected. Facility staff were inserviced by the Director of Nursing Services and Administrator regarding circumstances that require reporting including appropriate reporting timeframes. The Director of Nursing Services and/or designee will conduct a random audit (Attachment A) of five residents weekly for four weeks, every other week for four weeks, then monthly thereafter. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated, and reported timely to the appropriate parties. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the Director of Nursing Services and/or designee will randomly complete the audit to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	

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	to get up out of bed, resistant to care, anxiety and agitation. Interventions included: approach her from the front, provide reassurance and validation if hallucinating, when refusing care, come back later and reapproach her. A progress note, dated 11/12/23 at 8:30 a.m., indicated the resident had skin discoloration of unknown origin below her left eye and close to her eyebrow as well as on both wrists. There had been no documentation to indicate the resident had fallen or had behaviors prior to the injury being observed. An Initial Non-Pressure Skin Report, dated 11/11/23 at 10:40 a.m., indicated the resident was observed with a black area to her left eyebrow that measured 3 cm (centimeters) by 0.5 cm. Below her left eye and measuring 4 cm by 2.5 cm was a swollen, red/purple/black discolored area. Her left forearm, above her wrist, was a black discolored area which measured 8 cm by 3 cm and a black discolored area on her right forearm, above her wrist, which measured 6 cm by 2.5 cm. On 11/16/23 at 11:12 A.M., the Administrator and Regional Nurse were interviewed. The Administrator indicated Resident N had been given care at around 8:00 p.m. on 11/11/23 by an agency CNA (Certified Nurse Assistant). The injuries to the resident's face and arms was observed around 10:30 p.m. that same evening and an investigation started the following day. When questioned, the Regional Nurse indicated the facility should have reported to the Department of Health within the first 2 hours after finding the injuries due to the resident nor staff knowing how the injuries had occurred and the suspicious areas the bruises were located.			

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	A current copy of the facility policy, titled "Abuse, Neglect and Exploitation", was provided by the Administrator on 11/16/23 at 10:00 A.M., and stated: "Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse...This includes staff to resident abuse...B. Possible indicators of abuse include, but are not limited to...Physical injury of a resident of unknown source...Reporting/Response: The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframe's: a. Immediately, but no later than 2 hours after the the allegation is made, if the events that cause the allegation involve abuse and result in serious bodily injury...." This citation relates to Complaint IN00421741.			
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 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			

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	new ulcers from developing. Based on interview and record review, the facility failed to assess timely and follow physician orders for treatment of a pressure ulcer for 1 of 3 residents reviewed (Resident O). Findings include: On 11/16/23 at 11:51 P.M., Resident O's record was reviewed. The resident admitted to the facility following hospitalization for sepsis from skin infection of his lower extremities' chronic wounds. Other diagnoses included, diabetes and heart disease. A hospital discharge summary, dated 9/27/23 at 10:49 a.m., indicated the resident had been hospitalized for sepsis due to cellulitis of the lower extremities. While at his previous living facility, the wounds on his legs had become more swollen and red with increased drainage. Since admission to the hospital, his legs had improved significantly. "Notably, the resident had buttock wounds". The wound care team had been consulted and planned to treat the buttock wounds with melgisorb, mepilex border and he was to continue with wound care in the outpatient setting. Admission physician orders included: -Bilateral lower legs: wash with baby soap and water or normal saline; pat dry; apply mepilex ag; secure with stockinet and change every 3 days or as needed for soilage or dislodgement. -Buttocks: cleanse wound with mild soap and water; pack the wound with alginate and cover with mepilex (bandage).	F 0686	Resident O no longer resides at this facility. The facility has determined that all residents have the potential to be affected. A facility skin sweep has been completed any areas identified have been documented in the resident's clinical record/s. Facility staff were inserviced by the Director of Nursing Services regarding the facility policy and procedure for Wound Assessment. The Director of Nursing Services and/or designee will conduct a random audit (Attachment B) of three admissions weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the Director of Nursing Services and/or designee will randomly complete the audit to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	12/07/2023

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	A nurse note, dated 9/27/23 at 4:25 p.m. indicated the resident had been admitted from the hospital. He was alert and oriented. He had open areas to both lower extremities and to his left buttock. No description of the areas, the characteristics or type was noted. An Admission Evaluation, dated 9/27/23 at 5:19 p.m., indicated a head to toe skin assessment had been completed. The evaluation indicated he had 1 or more pressure ulcers and had other skin conditions. An Initial Pressure Ulcer Report, dated 9/27/23 at 6:50 p.m., indicated the resident had a pressure ulcer present upon admission. He had a pressure area to his left buttock and a blister on his right and left lower legs. The pressure ulcer was red with serosangious drainage (blood and clear fluid). There were no measurements of the wounds completed on the report. A TAR (Treatment Administration Record) dated September 2023 and October 1 and 2, 2023, didn't indicate the resident had received treatment for the pressure area to his buttocks or treatment to his lower legs as ordered. An admission physician visit, dated 9/28/23 at 1:54 p.m., indicated the resident was seen for admission to the skilled facility following hospitalization for sepsis due to cellulitis of lower extremities and increased drainage. He had chronic wounds and was followed by wound care. His active problem list included diagnoses of Stage 4 pressure area (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed) to the left			

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	buttock. His physical exam indicated he was morbidly obese. He had 3+ pitting edema to both lower legs with slight redness, no open wounds or seepage. The resident indicated his blisters had healed and the swelling and redness had improved during his hospital stay. The assessment and plan were for the resident to follow up on wound care recommendations. A nurse note by the facility wound nurse, dated 9/28/23 at 2:44 p.m., indicated the resident's skin had been assessed and no open areas were observed. He had no signs of infection, no complaints of pain, no drainage, no odor, and no swelling. A skilled nurse note, dated 9/28/23 at 5:06 p.m., indicated the resident was currently receiving physical and occupational therapy. His skin color was normal for him. He had a "pressure ulcer present-no drainage". There was no documentation of the size, stage or other characteristics of the wound. On 11/16/23 at 2:25 P.M., the facility wound nurse was interviewed. When questioned, he hadn't known there were physician orders to treat the resident's lower leg wounds or buttock wound. He indicated he had examined the resident's skin and hadn't seen any open area on the resident's buttocks, however, the resident had some type of scarring or "keloids" observed on his bottom. Since he hadn't seen any open areas on the resident's bottom or legs, he hadn't monitored the areas. On 11/16/23 at 2:54 P.M., LPN 3 (Licensed Practical Nurse) was interviewed. She indicated she had been the admitting nurse, had completed the admission evaluation and initial pressure ulcer			

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	report. She indicated she had examined the resident's arms and legs but hadn't looked at his bottom as the facility wound nurse would do an assessment. She was unable to recall where the serosangious fluid had been observed from the resident but indicated the blisters on his legs had been intact. The Director of Nursing (DON), who was present during the interview, indicated nurses were to assess all skin areas upon admission and were not to wait for the facility wound nurse to completed the assessment. On 11/17/23 at 2:09 P.M., the DON provided a current copy of the facility policy, titled "Wound Assessment" which stated: "It is the policy of this facility that wounds will be assessed and documented upon admission...Upon admission a full body skin assessment will be completed by the admitting nurse...Physician ordered treatments will be documented on the TAR after each administration...." This citation relates to Complaint IN00421612.			