STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155674	A. BUILDING 00 B. WING	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST CHARLES HEALTH CAMPUS	3150 ST CHARLES ST JASPER, IN 47546

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F 0000 Bldg. 00	This visit was for the investigation of complaint IN00457254. Complaint IN00457254: Federal/State deficiencies related to the allegations are cited at F686. Survey dates: April 22 & 25, 2025 Facility number: 002628 Provider number: 155674 AIM number: 200299110 Census Bed Type: SNF: 16 SNF/NF: 40 Residential: 39 Total: 95 Census Payor Type: Medicare: 22 Medicaid: 27 Other: 7 Total: 56 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on May 2, 2025.	F 0000		
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on interview and record review, the facility failed to ensure services were provided to prevent the development of pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. The facility	F 0686	We at Trilogy Health Services note St. Charles Health Campus would like to provide supportive documentation to demonstrate the F686 Treatment/Svcs to	05/17/2025

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

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	failed to obtain adequate physician orders or instructions following the removal of a non-removable brace, which resulted in the development of an unstageable pressure ulcer to the left heel (Wound 2). Following an assessment by a wound care clinic that indicated a newly developed unstageable pressure ulcer to the top of the left foot (Wound 3), the facility failed to assess the wound routinely or create a plan of care to address the wound. (According to the National Pressure Injury Advisory Panel [NPIAP], an unstageable pressure ulcer is defined as: wound is obscured by slough or eschar which makes depth and extent of tissue damage unable to be determined.) This deficient practice resulted in the facility failing to prevent and assess developed pressure wounds and failing to update the residents' plan of care for pressure wounds. (Resident D) Findings include: During record review on 2/3/25 at 10:30 A.M., Resident D's diagnoses included, but were not limited to fracture of left tibia, Alzheimer's disease, dementia and anxiety. Resident D's most recent admission Minimum Data Set (MDS) assessment, dated 8/15/24, indicated the resident was admitted to the facility with one unhealed unstageable pressure ulcer (Wound 1), was at risk for developing pressure ulcers, and had severe cognitive impairment. A Braden scale assessment (tool used to predict the risk for developing pressure ulcers), completed 8/12/24, indicated Resident D was at moderate risk for developing pressure ulcers. Resident D's physician orders included, but were		Prevent/Heal Pressure Ulcer, CFR(s): 483.25(b)(1)-(3) should not have been cited at the scope and severity of G level. To follow the requirements to meet the IDR process, St. Charles Health Campus has referred to the **CMS State Operations Manual Chapter 7- 7212.3- Mandatory Elements of Informal Dispute Resolution Pg. 37-38. (Exhibit A)** The submission of this plan of correction does not indicate an admission by St. Charles Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of St. Charles Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for	

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	not limited to, non-weight bearing to left lower extremity (started 8/12/24), apply foam dressing to deep tissue injury to left great toe (Wound 1) (started 8/1/2/25), observe non-removable dressing to left lower extremity for drainage on dressing and for dislodgement, leave splint in place, do not remove, call orthopedic physician if the brace gets wet (started 8/12/25), cleanse left heel wound (Wound 2), cover with heel foam dressing, cast padding from toes to just below knee, ace wrap from toes to knee, apply heel lift boot (started 8/27/25), cover wound on heel (Wound 2), left great toe (Wound 1), and top of left foot (Wound 3) with bordered foam-wrap, change dressing every other day and assess wounds (started 9/5/25). Resident D's care plan included, but was not limited to, resident has a pressure ulcer to the left great toe (Wound 1) upon admission (initiated 8/14/24) and left heel (Wound 2) (revised 8/29/25). Resident demonstrates non-compliance with plan of care as evidenced by removing dressing and splint (initiated 8/15/25 and revised 9/10/25.) Resident at risk for skin breakdown (initiated and last revised 8/29/25). Resident D's care plan did not include a focus specific to the pressure ulcer to the top of the left foot (Wound 3). Resident D's progress notes included, but were not limited to: 8/12/24 at 12:35 P.M. - Resident arrived at facility with splint/wrap in place to left lower extremity. The family discussed deep tissue injury to the top of the left great toe (Wound 1) that measured 1.5 centimeters (cm) (length) x 1 cm (width) potentially caused by the previous hard splint.		substantial compliance. Completion Date: 5/17/25 Plan of Correction Text: F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1 What corrective action was taken for the resident affected by the alleged deficient practice. Resident D no longer resides in the facility. Current residents with non-removable dressings/splints were reviewed to ensure physician treatments and wound documentation were in place and care plans were up to date. 2 What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice? All residents with wounds have the potential to be affected. Nurse's have been educated on wound documentation, physician orders and care plans being updated per policy. 3 What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur. DHS or designee will review physician orders for non-removable dressings/splints, appropriate documentation during clinical care meeting and audit 5 residents weekly for 4 weeks, then every	

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	8/13/24 at 2:37 A.M. - Resident had a fracture to the left lower extremity with a non-removable splint in place. 08/15/24 at 2:55 A.M. - Resident continued to remove dressing and splint to left lower extremity. Resident removed dressing two times this shift. 8/16/24 at 3:34 A.M. - Resident continued to be non-compliant with non-weightbearing orders and non-compliant with orders for non-removable dressing and splint to the left lower extremity. The surgical incision site was red and warm to the touch with serosanguineous drainage noted. Orthopedic physician's office notified and awaiting response. Resident complained of pain to the lower left extremity earlier in the shift and treated with pain medication. 8/26/24 at 6:48 P.M. - Resident returned from appointment at orthopedic physician's office with Physician Assistant (PA) 4 with new orders for: 1. Strict non-weight bearing. 2. Daily skin checks. 3. Wound care to the left heel pressure ulcer (Wound 2). 4. Pad heel. 5. Elevate but no direct heel pressure. 08/27/24 at 3:08 P.M. - Staff spoke with resident's family member regarding concern of left heel skin impairment. Also spoke with PA 4 at orthopedic physician's office to update that family was planning to follow up with the wound care clinic. Treatment orders updated and wound management initiated. 08/28/24 at 8:47 A.M. - Resident admitted with deep tissue injury to let great toe (Wound 1). At an orthopedic appointment, the splint was		other week for 2 months, and then monthly for 3 months Minimum Data Set Coordinator or designee will update care plans during clinical care meeting and audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	removed with noted pressure to left heel (Wound 2). Resident admitted with non-removable splint to left lower extremity, however the resident removed frequently. Orthopedic physician office updated regarding removal of splint. 09/04/24 at 8:27 A.M. - Upon entering the resident room for assessment and treatment, the left lower extremity dressing and boot had been removed by the resident. 09/11/24 at 8:00 A.M. - Resident continued to remove dressing and boot frequently. Noted two scabs to top of left foot on this date, foam dressing in place. Distal area is 3 cm x 0.5 cm, and proximal area is 2 cm x 0.3 cm. 10/08/24 at 3:50 P.M. -Resident returned from wound care clinic with a "football dressing" to left foot. This dressing to only be changed weekly per wound care clinic. 10/09/24 at 6:54 A.M. Resident removed football dressing to left foot. Called family to update. Resident D's left heel wound (Wound 2) assessments included but were not limited to the initial wound assessment dated 8/28/24 at 8:45 A.M., 3.2 cm x 3.6 cm, unable to determine depth, no drainage, no odors, unstageable deep tissue injury. Weekly left heel wound assessments were completed. No weekly assessments were completed for Resident D's left top of foot unstageable pressure ulcer (Wound 3). Resident D's orthopedic physician's office visit notes included, but were not limited to: 8/26/24 - Patient's visit note - Resident D returned			

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	for follow up status post Open Reduction Internal Fixation (ORIF) procedure of tibial fracture performed 8/9/24. Family stated resident had some compliance issues and was walking on the postoperative splint. The facility took down the splint and has reportedly replaced it several times. Physical Findings (left foot exam) Resident has a new heel pressure ulcer (Wound 2) that is about the size of a silver dollar. There is concern for potential necrotic tissue. 9/12/24 - Patient's visit note - Resident D returned for follow up status post ORIF procedure of tibial fracture performed 8/9/24. She has a heel ulcer (Wound 2) from a misapplied splint. Resident D's wound clinic visit notes included, but were not limited to: 9/3/24 - Wound visit notes did not include an assessment of Resident D's wounds but did include new treatment order comments of; cover wounds on heel (Wound 2), left great toe (Wound 1), and top of left foot (Wound 3) with bordered foam dressing and remove every other day to assess the site for breakdown and replace the foam boarder. 9/17/24 - Wound care orders included wound location of left heel (Wound 2), left dorsal (upper side or top) foot (Wound 3), and left first toe (Wound 1). 10/8/24 - Wound assessments for the left dorsal (top) foot wound first assessed on 9/3/24 included the wound measurements of 0.5 cm x 0.3 cm x 0.1 cm (depth). (Wound 3) 10/22/24 - Wound care orders included associated diagnoses an unstageable pressure ulcer of dorsum of left foot (Wound 3) and unstageable			

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	pressure ulcer of left heel (Wound 2). During an interview on 4/25/25 at 9:30 A.M., PA 4 indicated having observed Resident D on 8/26/24 during a two week post operative appointment. PA 4 indicated a non-removable splint was applied in the orthopedic physician's office following the Resident's surgical procedure. PA 4 indicated the resident's left foot was wrapped with a padded dressing and a hard splint was applied over the padding. When Resident D arrived for the appointment on 8/26/24, the splint had been applied incorrectly with the padded dressing wrapped around the outside of the hard splint and had resulted in a pressure area to the left heel (Wound 2). PA 4 indicated he was unaware of any notification from the facility regarding Resident D removing the splint and dressing prior to her appointment on 8/26/24. During an interview on 4/25/25 at 10:05 A.M., the Director of Nursing (DON) indicated the wound on top of Resident D's left foot (Wound 3) was assessed on 9/11/24 at the facility as a scabbed area and not a pressure ulcer, therefore the wound was not entered into a wound management program that would have initiated routine wound assessments. During an interview on 4/25/25 at 11:00 A.M., the DON indicated that the orthopedic physician's office did not respond to the notification attempt documented on 8/16/24, and the facility staff replaced the non-removable splint themselves (prior to the development of the unstageable pressure ulcer to Resident D's left heel (Wound 2). The facility did not reassess the area on top of Resident D's left foot (Wound 3) following the diagnosis of an unstageable pressure ulcer to the area during a wound care clinic visit on 10/22/24.			

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	No weekly assessments of that wound were documented. During an interview on 4/25/25 at 12:10 P.M., LPN 8 indicated nursing staff should document when a physician's office is notified and if awaiting reply. Nursing staff should continue to contact the physician's office if a reply is not received and should document all attempts of notification. On 4/25/25 at 1:30 P.M., the DON supplied a facility policy titled, "Guidelines for Pressure Prevention", dated 12/17/24. The policy included, "Care plan interventions shall be implemented based on risk factors identified in the nursing assessment.... Inspect the skin daily during care of signs of breakdown or changes to the skin... Utilize padding for casts and splints. Monitor skin closely when these devices are present..." This citation relates to complaint IN00457254. 3.1-40(a)(2)			