STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 31, November 1, 2, 3 and 7, 2022 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census bed type: SNF/NF: 41 Total: 41 Census payor type: Medicare: 1 Medicaid: 31 Other: 9 Total: 41 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 10, 2022.	F 0000		
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review, and interview, the facility failed to ensure weekly skin assessments accurately reflected the residents current skin status and therapy evaluation for a helmet assessment were document for 2 of 13 residents reviewed for skin impairments. (Residents 6 and 4)	F 0641	1.)Corrective action for affected residents: Res# 4 discharged to hospital w/o return therefore no action can be taken at this time Res# 6 Area remains with thick scab/callous that is intact.	12/05/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven	Cunningham	12/05/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: 1. During an observation of wound care for Resident 6 on 11/3/22 at 11:20 a.m., the Wound Nurse indicated the resident had a scabbed area to the back of her right heel which was being treated for several months. The clinical record for Resident 6 was reviewed on 11/1/22 at 9:35 a.m. The diagnoses included, but were not limited to, Type 2 diabetes mellitus with diabetic chronic kidney disease, unspecified protein-calorie malnutrition, and unsteadiness on feet. The facility Weekly Skin and Edema assessments between August and October 2022 indicated the following assessments were not coded correctly: The Weekly Skin and Edema assessment, dated 8/4/22, indicated the resident's skin integrity was intact/unbroken skin. Resident had no skin issues. The Pressure Wound assessment, dated 8/5/22, indicated the resident had a right heel pressure ulcer, length 1.4 cm (centimeters) by 1 cm by 0.2 cm Stage 3. The Weekly Skin & Edema assessment, dated 8/11/22, indicated the resident had intact/unbroken skin. Staff were to continue with treatment to the left heel and Nystatin powder under the abdominal folds. The Weekly Skin & Edema assessment, dated 8/18/22, indicated the resident had intact/unbroken skin. The resident's right heel treatment was in place to the resident's heel related to skin breakdown.		Continue with current treatment and all current interventions. Res#33 Pressure area healed no additional action at this time other than to continue with current interventions. 2.)How other residents will be identified: Skin assessments completed on all residents by administrative nurses. (see attached) 3.)Systemic changes: Education on appropriately assessing skin and completing skin assessments to be completed shift to shift. (see attached education information). Continue with weekly skin assessments per scheduled day. Weekly skin/edema assessment updated to provide more skin integrity options for better clarity when completing (see attached) and will be included in education. Rehab Manager indicated that guide book for ordering helmets will be followed in the future and therapy will complete documentation of evaluation or fitting, however there is currently no one in need of fitting. 4.)Monitoring: Attached QA will be completed by administrative nurse or designee to monitor weekly skin assessment accuracy, assistive device use such as helmet, brace or splint and careplan updates/appropriateness. This QA will be completed by admin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The Weekly Skin & Edema assessment, dated 8/25/22, indicated the resident had intact/unbroken skin. Staff were to apply Nystatin powder under the abdominal folds, facility barrier cream to the buttocks, treatment to the right heel continued. The Weekly Skin & Edema assessment, dated 9/1/22, indicated the resident had intact/unbroken skin. Staff were to apply Nystatin powder under the abdominal folds, facility barrier cream to the buttocks, treatment to the right heel continues. The Weekly Skin & Edema assessment, dated 9/8/22, indicated the resident had intact/unbroken skin. Staff were to continue with treatment to the right heel. The Weekly Skin & Edema assessment, dated 9/15/22, indicated the resident had intact/unbroken skin. Treatment continued to the resident's right heel. The Weekly Skin & Edema assessment, dated 9/22/22, indicated the resident had intact/unbroken skin. Staff were to continue to apply Nystatin powder under the resident's abdominal folds. The Weekly Skin & Edema assessment, dated 9/29/22, indicated the resident had intact/unbroken skin. The Weekly Skin & Edema assessment, dated 10/13/22, indicated the resident had intact/unbroken skin. The Weekly Skin & Edema assessment, dated 10/20/22, indicated the resident had		nurse or designee every week for each resident x 4 weeks, then every other week for 8 weeks, then 1x monthly for 3 months with QAPI committee to determine when to end following the 6 month monitoring. 5.) Addendum: QA will continue for at least 6 months per schedule. QA can be stopped after 6 months if there have been no identified issues with prompt identification/documentation of new pressure areas for 2 consecutive months. If there has been an identified issue QA will continue until there are 2 consecutive months without any identified issues with prompt identification/documentation of new pressure areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

intact/unbroken skin. The resident's treatment to the right heel was intact.

The Weekly Skin & Edema assessment, dated 10/27/22, indicated the resident had intact/unbroken skin. Staff were to apply skin prep to the resident's scabbed area on the right heel.

The Pressure Wound assessment, dated 10/25/22, indicated the resident's right heel remained Unstageable measuring 0.7 by 0.8 by 0. (Scab at the present site)

During an interview with the Wound Nurse on 11/3/22 at 11:20 a.m., she couldn't explain why the weekly skin assessments were indicating intact unbroken skin or why the nurses would also write treatment continues to heel. If treatment continued to the heel it would mean that the skin was not intact. All she could do was "educate, educate, educate".

During an interview with the Director of Nursing (DON) on 11/3/22 at 2:45 p.m., she indicated she was aware of the assessments not being coded correctly. All she could do was go over with the nurses on completing the weekly skin assessments to make sure they were being filled out correctly.
2. The clinical record for Resident 4 was reviewed on 11/1/22 at 10:03 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, traumatic subdural hemorrhage with loss of consciousness status, laceration with foreign body of the scalp, repeated falls, laceration without foreign body of part of the head, syncope and collapse, and orthostatic hypotension.

The clinical record lacked documentation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	therapy notes related to an evaluation or fitting for the soft helmet size. The nurse's note, dated 10/10/22 at 6:27 a.m., indicated the resident was found on the floor. She had a laceration to her head and was sent out to the hospital. The resident was diagnosed with a subdural hematoma from the fall. The physician's order, dated 10/11/22, indicated to encourage wearing of the soft helmet every day and night shift for fall risk. The Initial Pressure Wound Assessment, dated 10/29/22, indicated a suspected deep tissue injury to the right outer ear, measuring 0.3 cm long by 0.2 cm wide. The nursing staff were to monitor the skin integrity to the ears, jawline, and neck every shift related to the wearing of the soft helmet. A potential supply of another style of helmet was to be looked into, if available. During an interview on 11/7/22 at 9:27 a.m., the Rehabilitation Manager indicated the facility asked her to measure for the soft helmet. She had to guess on the size, because the resident was in the hospital at that time. She just found a resident with a similar sized head and used that as a guide for the helmet fit. She was not told of the rubbing and suspected deep tissue injury on the resident's ear, from the helmet. The facility had not asked her to find a different helmet. To properly fit a helmet, she would follow the guide book for ordering a helmet. She would measure the circumference of the resident's head usually. During an interview on 11/7/22 at 9:52 a.m., the Wound Nurse indicated therapy was consulted for the helmet to prevent further head injuries. She had assumed that therapy had fitted the helmet.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	She didn't feel the helmet was tight on the resident. The helmet had a Velcro strap under the chin. She was unsure if another helmet would be ordered. The resident was very demented and was unable to follow direction, and they had exhausted all interventions. The current therapy company's Position Description and Criteria, provided by the DON (Director of Nursing) on 11/7/22 at 12:34 p.m., included, but was not limited to, "... 15. Provides/recommends/fabricates adaptive devices, orthotics or prosthetics..." 3.1-31(a) 3.1-31(d) 3.1-31(e)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to ensure timely revision of a resident's care plan to reflect new pressure wound interventions for 1 of 13 residents whose care plans were reviewed. (Resident 33) Findings include: The clinical record for Resident 33 was reviewed on 11/3/22 at 11:15 a.m., the diagnoses included but were not limited to, fatigue, dyspnea, dementia, chronic kidney disease stage 3, pneumonia, bacterial infection, sepsis, urinary tract infection, abnormal weight loss, abnormality of albumin, history of falling, muscle weakness, difficulty walking, psychotic disturbance, mood disturbance, and anxiety disorder. The Quarterly MDS (Minimum Data Set) assessment, dated 9/19/22, indicated the resident was severely cognitively impaired. She required extensive assistance of two staff members for ADL's (Activities of Daily Living). She was at risk for developing pressure wounds. The physician's orders, with a start date of 10/20/22, indicated an air cell therapy mattress was to be on her bed at all times; palliative skin care; cleanse the wound to her left buttock with wound cleanser; pat dry and apply a hydrocolloid dressing daily, every night shift, for impaired skin	F 0657	1.)Corrective action for affected resident: Res #33 Pressure area has healed no additional action at this time other than to continue with current interventions and continue with weekly skin assessments. 2.)How other residents will be identified: Skin assessments completed on all residents by administrative nurses. Any resident that has been identified or is continuing with pressure wound(s) either upon admission or after admission have had C/P's reviewed. Individual careplans have been completed for pressure if the identified issue was previously combined with another potential for or current skin issue (see attached). 3.)Systemic changes: DON and/or ADON (wound nurse) are responsible for wound careplans and process will be changed to have individual careplans for pressure and not combine with other skin impairment or potential for skin impairment careplans.	12/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	integrity and as needed for soilage and dislodgement; nutritional juice; magic cups with meals for supplement; and liquid protein two times a day. The resident's care plan, dated 3/14/18 and revised on 11/1/22, indicated the resident was at risk for skin breakdown. The interventions included, but were not limited to, assist with repositioning (dated 3/14/18), and pressure redistribution mattress in place to the bed (dated 11/1/22). The resident's care plan, dated 8/18/19 and revised on 10/12/22, indicated the resident had the potential for skin integrity breakdown due to a history of chronically picking at her arms and had dry fragile skin. The resident had a Stage 3 pressure wound versus trauma area to her left buttock. The interventions included, but were not limited to, alternating air mattress (dated 11/1/22), complete treatments as ordered (dated 8/18/19), encourage good nutrition (dated 8/18/19) and hydration to promote healthier skin, encourage her to avoid scratching (dated 8/18/19), assist with keeping hands clean and fingernails short (dated 8/18/19), keep her skin clean and dry and use lotion on dry skin. Place pool noodle pieces to her wheelchair to keep her from her hitting legs (dated 9/8/22). The clinical record lacked documentation of any revision to the care plan with the interventions for a Stage 3 pressure wound. The Weekly Skin and Edema assessment, dated 10/10/22, indicated the resident had an abrasion to her left calf. The nurse's note, dated 10/12/22 at 4:21 p.m.,		4.)Monitoring: Attached QA will be completed for each identified pressure injury for careplan completeness/accuracy every week for each resident x 4 weeks, then every other week for 8 weeks, then 1x monthly for 3 months with QAPI committee to determine when to end following the 6 month monitoring. 5.) Addendum: QA will continue for at least 6 months per schedule. QA can be stopped after 6 months if there have been no identified issues with prompt identification/documentation of new pressure areas for 2 consecutive months. If there has been an identified issue QA will continue until there are 2 consecutive months without any identified issues with prompt identification/documentation of new pressure areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

indicated while completing incontinent care an area was observed to be open on the resident's left buttock that was pressure versus trauma area and measuring 2 cm (centimeters) x 2 cm x 1 cm. She had no pain, no drainage, no signs, or symptoms of infection. The surrounding area was normal skin tone. The new orders were received and noted to cleanse the wound with wound cleanser, pat dry and apply a hydrocolloid dressing daily and prn (as needed) for soilage or dislodgement.

The Wound Assessment Form, dated 10/12/22 at 4:00 p.m., indicated the left buttock pressure wound measured 2 cm by 2 cm by 1 cm and at a Stage 3. No exudate, and the surrounding skin was intact.

The Wound Assessment Form, dated 10/27/22, indicated the left buttock pressure wound measured 1 cm by 1 cm by 0.2 cm and was a Stage 3. A scant amount of serous drainage, the wound bed was pink, and the surrounding tissue was intact.

During an interview on 11/3/22 at 11:00 a.m., the Wound Nurse indicated when an issue like a pressure wound was identified she would be notified by the staff and interventions would be added at that time. The care plan would be updated or the issue would be added at that time with interventions. If the current interventions were not working, she would reassess the wound and add new interventions.

The Wound Management Program policy, dated 8/1/2018, was provided by the DON (Director of Nursing) on 11/1/22 at 10:00 a.m. The policy included, but was not limited to, "... F. Documentation and Care Planning 1. The wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	management program documentation requirements include: a. Identification of the location and frequency of wound documentation. b. Identification of forms used and format for reporting. c. Required comprehensive description of pressure ulcer weekly, at a minimum. d. Delineation of 'in-house' documentation required (for example, weekly reports to the Director of Nurses) and by whom. e. Goals of the wound care plan collaboratively determined with the resident, family, and interdisciplinary team. f. Assigned responsibility/accountability for the initial care plan and for subsequent updating. g. Determined facility time frames for care plan updating ..." 3.1-35(d)(2)(B)			
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 new ulcers from developing.			
	Based on record review, observation, and interview, the facility failed to ensure thorough skin assessments were conducted to identify pressure wounds prior to the development of a Stage 3 and unstagable pressure ulcer and failed	F 0686	1.)Corrective action for affected residents: Res# 4 discharged to hospital w/o return therefore no action can be taken at this time	12/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	to ensure proper procedures were followed for an assistive device which resulted in a suspected deep tissue injury for 3 of 3 residents reviewed for pressure wounds. (Residents 33, 6, and 4) Findings include: 1. The clinical record for Resident 33 was reviewed on 10/31/22 at 10:50 a.m. The resident's diagnoses included, but were not limited to, sepsis, dementia, stage 3 kidney disease, pneumonia, bacterial infection, urinary tract infection, abnormal weight loss, hypoxia, difficulty walking, Alzheimer's, and hypertension. The Quarterly MDS (Minimum Data Set) assessment, dated 9/19/22, indicated the resident was severely cognitively impaired. She required extensive physical assistance of two staff members for ADLs (Activities of Daily Living). She was at risk for developing pressure wounds. The physician's orders, with a start date of 10/20/22, indicated an air cell therapy mattress was to be on her bed at all times; palliative skin care; cleanse the wound to her left buttock with wound cleanser; pat dry and apply a hydrocolloid dressing daily, every night shift, for impaired skin integrity and as needed for soilage and dislodgement; nutritional juice; magic cups with meals for supplement; and liquid protein two times a day. The resident's care plan, dated 3/14/18 and revised 8/18/19, indicated the resident was at risk for skin breakdown. The interventions included, but were not limited to, assist with repositioning and pressure redistribution mattress in place to the bed.		Res# 6 Area remains with thick scab/callous that is intact. Continue with current treatment and all current interventions. Res#33 Pressure area healed no additional action at this time other than to continue with current interventions. 2.)How other residents will be identified: Skin assessments completed on all residents by administrative nurses (see attached). There are currently no residents with orders for helmet, brace or splint to be in place at all times. 3.)Systemic changes: Education on appropriately assessing skin, completing skin assessments and to have orders in place for checking skin integrity if resident has orders for helmet, brace or splint at all times will be completed shift to shift. (see attached education). Continue with weekly skin assessments per scheduled day. Weekly skin/edema assessment updated to provide more skin integrity options for better clarity when completing (see attached) and will be included in education. 4.)Monitoring: Attached QA will be completed for each identified pressure injury for careplan completeness/accuracy every week for each resident x 4 weeks, then every other week for 8 weeks, then 1x monthly for 3 months with QAPI committee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The resident's care plan, dated 8/18/19 and revised on 10/12/22, indicated the resident had the potential for skin integrity breakdown due to a history of chronically picking at her arms and had dry fragile skin. The resident had a stage III pressure wound versus trauma area to her left buttock. Interventions included, but were not limited to, alternating air mattress, complete treatments as order, encourage good nutrition and hydration to promote healthier skin, encourage her to avoid scratching, assist with keeping hands clean and fingernails short, keep her skin clean and dry and use lotion on dry skin, and place pool noodle pieces to her wheelchair to keep her from her hitting legs. The Weekly Skin and Edema assessment, dated 10/10/22, indicated the resident had an abrasion to her left calf. The Wound Assessment Form, dated 10/12/22 at 4:00 p.m., indicated the left buttock pressure wound measured 2 cm by 2 cm by 1 cm and at a stage III. No exudate, and the surrounding skin was intact. The nurse's note, dated 10/12/22 at 4:21 p.m., indicated while completing incontinent care an area was observed to be open on the resident's left buttock that was a pressure versus trauma area and measuring 2 cm (centimeters) by 2 cm by 1 cm. She had no pain, no drainage, no signs, and symptoms of infection. The surrounding area was normal skin tone. New orders were received and noted to cleanse the wound with wound cleanser, pat dry and apply a hydrocolloid dressing daily and prn for soilage or dislodgement. The nurse's note, dated 10/17/22 at 1:31 p.m., indicated the treatment to her left buttock was continued and tolerated well. The area showed		determine when to end following the 6 month monitoring. 5.) Addendum QA will continue for at least 6 months per schedule. QA can be stopped after 6 months if there have been no identified issues with prompt identification/documentation of new pressure areas for 2 consecutive months. If there has been an identified issue QA will continue until there are 2 consecutive months without any identified issues with prompt identification/documentation of new pressure areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	some improvement with zero signs or symptoms of infection, zero drainage or active bleeding. The Wound Assessment Form, dated 10/19/22, indicated the left buttock pressure wound measured 1.4 cm by 1 cm by 0.2 cm at a stage III. A scant amount of serous drainage, and the surrounding skin was intact. The nurse's note, dated 10/26/22 at 1:38 p.m., indicated the treatment continued to the resident's left buttock with zero signs or symptoms of infection, zero drainage or active bleeding. Pillows were placed to relieve pressure. No signs or symptoms of pain. The Wound Assessment Form, dated 10/27/22, indicated the left buttock pressure wound measured 1 cm x 1 cm x 0.2 cm and was a Stage 3. A scant amount of serous drainage, the wound bed was pink, and the surrounding tissue was intact During an interview on 11/3/22 at 8:35 a.m., LPN (Licensed Practical Nurse) 1 indicated nurses did weekly skin checks usually when the resident received a shower. A pressure wound should have been identified before it was a stage III. The skin should be monitored for redness, edema, pain, no blanchable skin, and breaks in the skin. The residents should be turned and repositioned every 2 hours, low air mattress and float the heels. During an interview on 11/3/22 at 10:00 a.m., the Wound Nurse indicated the resident's wound was facility acquired. Interventions for prevention include a alternating air mattress, pressure reduction cushion to the resident's wheelchair, float the heels with a pillow, turn and reposition every 2 hours and as needed, and dietary consult			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	for nutrition. If a resident developed a pressure area the staff would inform her. The skin assessments were done weekly. A pressure wound should be found before it reached a stage III. There would be signs and symptoms before the wound reached a stage III. She would stage the wound, but staff could and if the wound was staged wrong she wound assess the wound and change the staging. A wound care consultant would come in monthly to assess the wounds. She could them anytime a wound developed or worsened. She would monitor the wounds weekly. During an observation on 11/7/22 at 11:00 a.m., Resident 33's wound was observed. The wound bed had improved with a thin layer of bright pink skin. 2. The clinical record for Resident 6 was reviewed on 11/1/22 at 9:35 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, unspecified protein-calorie malnutrition, and unsteadiness on feet. The Quarterly MDS assessment, dated 7/26/22, indicated the resident was cognitively intact with the need for cues for recall and temporal orientation to day of week and month; had no mood or behavior issues; required supervision with one staff member's assistance for bed mobility and transfers; needed limited assistance of one staff for ambulation on/off the unit with a walker; was not steady in balance and required staff assist to stabilize; had no impairment in functional ROM (range of motion); had no present pressure ulcer, and was not at risk for development of a pressure ulcer. The Annual MDS assessment, dated 10/17/22, indicated the resident remained the same, except			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

she currently had a Stage 3 pressure ulcer that was not healed. She remained not at risk for development of a pressure ulcer.

On 6/5/22, a physician's order was obtained for an alternating air mattress to her bed at all times and to check it's function every shift, every day and night shift for palliative care.

The facility Weekly Skin and Edema assessment, dated 8/4/22, indicated the resident's skin integrity was intact with unbroken skin. The resident had no skin issues.

The Pressure Ulcer Assessment, dated 8/5/22, indicated the resident had a Stage 3 right heel ulcer which measured 1.4 cm by 1.0 cm by 0.2 cm. Appeared as if it had been blistered and then ruptured. Treatment ordered.

Upon discovering the Stage 3 pressure ulcer, the following new physician's orders were obtained to:
- encourage the resident to turn and reposition every 2 to 3 hours or float heels every day and night shift.
- Liquid Protein Supplement two times a day for the wound to the right heel 30 ml (milliliters) each administration - 60 ml total.
- cleanse wound to the right heel with wound cleanser or soap and water, pat dry. Mix collagen powder with wound gel to make a paste. Apply paste to wound on the right heel and cover with foam dressing at bed time (night).
- A multivitamin daily.

The Pressure Ulcer Assessment, dated 8/11/22, indicated the right heel measured 1.2 cm by 0.9 cm by 0.2 cm and was a Stage 3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A Nutrition/Dietary Note, dated 8/16/22 at 3:36 p.m., indicated the resident was going to be added to the Nutrition At Risk (NAR) program related to the Stage 3 pressure injury to the left heel. The Pressure Ulcer Assessment, dated 8/18/22, indicated the right heel measured 1.0 cm by 1.0 cm by 0.2 cm and was a Stage 3. The resident was non cooperative with elevating her heel off the bed. She was educated multiple times and encouraged to float her heel with pillows. She independently moved in bed, and in and out of bed. A nursing note, dated 8/23/22 at 12:01 a.m.,. indicated the wound to the right heel continued. The wound bed was yellow with a scant amount yellow drainage. Staff continued to encourage the resident to her float heels to prevent worsening to the area. The Pressure Ulcer Assessment, dated 8/25/22, indicated the wound to the right heel measured 1.0 cm by 1.0 cm by 0 cm and was unstageable. The wound bed had > (greater than) 85% slough. A new treatment ordered due to the presentation of slough to the wound bed. On 8/25/22, a new physician's order was obtained to change the wound treatment to: clean the wound to the right heel with soap and water or wound cleanser. Apply Santyl to the wound bed and cover with a border gauze dressing. A nursing note, dated 8/27/22 at 11:34 p.m., indicated there was no improvement noted to the heel wound. A scant amount yellow/brown drainage was observed on the previous dressing. The resident continued to complain of pain with pressure to the area. No odor was detected .			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

A nursing note, dated 8/30/22 at 1:18 a.m., indicated no changes to the heel wound were noted. The wound bed was yellow with white tissue to the surrounding wound edges with a scant amount yellow drainage. The resident indicated the area only hurt when pressure was applied.

A Nutrition/Dietary note, dated 8/30/22 at 2:51 p.m., indicated the resident was to continue to receive liquid protein and multivitamin. The note corrected the previous entry on 8/16/22 to reflect the right heel was impaired, not the left. The diagnosis of type 2 diabetes was present and may delay healing of skin related to poor circulation. Intakes of food and fluid were good. No new recommendations. Continue to follow on NAR for stability.

The Pressure Ulcer Assessments, dated 9/1/22 and 9/8/22, indicated the right heel measured 1.0 cm by 1.0 cm by 0 cm and was unstageable. The wound bed was approximately 50 % (percent) slough to 50 % red beefy tissue. The resident not cooperative with floating her heels. The resident was independent with mobility in bed and with transfers. The resident was educated and provided pillows and/or wedge to prop her heels up off the bed.

A nurses note, dated 9/4/22 at 11:01 p.m., indicated treatment continued to right heel pressure area. The wound bed was pale yellow; skin around the edges was white with scant amount yellow drainage on the previous dressing. Santyl was applied to wound bed as directed. The resident stated the area was painful only when pressure was applied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The nursing notes, dated 9/5/22 at 10:50 p.m. and the 9/12/22 at 12:56 a.m., both indicated the pressure area to the right heel appeared much the same with no improvement noted. The wound bed was pale yellow and skin at the edges was white with scant or no amount of yellow drainage on the dressing. The resident continued to require frequent reminders to elevate her heels off the mattress. The Pressure Ulcer Assessment, dated 9/15/22, indicated the right heel had the same measurements as last week's assessment, but the wound bed now had 70 % red tissue and 30 % yellow slough. The resident remained non cooperative with floating her heel off the bed. The nursing note, dated 9/22/22 at 5:15 p.m., indicated a new order was received today to change the treatment to the right heel wound. The wound consultant was here today for a monthly visit and recommended to discontinue the Santyl. The wound bed was pink and improving. The Wound Care note, dated 9/22/22, indicated a new order to continue to use Composite to cover the wound and provide bacterial barrier. Daily dressing changes were required due to difficult location due to friction and sheer from the sheets, and clothes that dislodged the dressing within 24 hours. The Pressure Ulcer Assessments, dated 9/22/22 and 9/29/22, indicated the right heel measured 1.0 cm by 1.0 cm by 0.2 cm and was now a Stage 3. The resident continued to be non cooperative with floating her heel. The nursing note, dated 10/1/22 at 2:18 a.m., indicated the area to right heel was closed at this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

time.

The nursing note, dated 10/2/22 at 12:13 a.m., indicated the treatment continued to the right heel. The area was scabbed and surrounding skin area was red with no drainage.

The Pressure Ulcer Assessment, dated 10/5/22, indicated the right heel measured 1.0 cm by 1.0 cm by 0.2 cm and was now a Stage 3. The resident continued to be non cooperative with floating her heel.

The Pressure Ulcer Assessments, dated 10/12/22 and 10/19/22, both indicated the right heel measured 0.8 cm by 0.8 cm by 0.2 cm and was a Stage 3.

The Pressure Ulcer Assessment, dated 10/25/22, indicated the right heel measured 0.7 cm by 0.8 cm by 0 cm and was unstageable due to a scab being present.

The new physician's orders, dated 10/25/22, were for skin prep wipes to apply to the right heel topically every day and night shift for the scabbed healing pressure area. If scab comes off and the area re-opens, staff would need to change treatment to the area.

A care plan, dated 4/26/21 with a revision date of 8/5/22, indicated the resident had the potential for impaired skin integrity due to a Stage 3 left heel which developed on 8/5/22. The interventions included, but were not limited to, alternating air mattress to bed (dated 8/9/22); document the skin status at least weekly (dated 4/26/21); encourage good nutrition and hydration in order to promote healthier skin (dated 4/26/21); encourage meds/supplements as ordered (dated 8/8/22);

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

encourage to keep the skin clean and dry (dated 8/9/22); encourage to turn side to side and/or float heels (dated 8/9/22); observe skin impairment for delayed healing or signs or symptoms of infection and notify MD/NP (Medical Doctor/Nurse practitioner) as needed (dated 4/26/21); and treatment as ordered (dated 4/26/21).

The clinical record indicated the pressure wound was on the right heel, not the left.

During a wound observation and interview on 11/3/22 at 11:20 a.m., the Wound Nurse indicated the right heel wound was thought to have started out as a blister and then it broke and was now scabbed over. Staff continued to treat the scab as it was unknown as to what was underneath the scab. She was very surprised when it was discovered as the resident was mobile and although she spent majority of time in bed, she did get up to the bathroom and moved about in her room. The wound consultant informed staff the blister should be coded as a Stage 3. The resident did not always keep her feet elevated like she should. The resident indicated that she forgot sometimes to elevate her feet.

During an interview with the Director of Nursing (DON) on 11/3/22 at 2:45 p.m., she indicated nursing debated between the resident's wound being slough or a Stage 3 and it was decided to go with the higher staging of a Stage 3 due to the scab.

3. The clinical record for Resident 4 was reviewed on 11/1/22 at 10:03 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, traumatic subdural hemorrhage with loss of consciousness status, laceration with foreign body (staples) of the scalp, repeated falls, laceration without foreign body of part of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	head, syncope and collapse, and orthostatic hypotension. The Quarterly MDS assessment, dated 10/13/22, indicated the resident was severely cognitively impaired. The resident required limited assistance of one staff for transfers and bed mobility. She required extensive assistance of one staff for walking in her room and corridor, locomotion on and off unit, dressing, and toileting. She required supervision for eating and personal hygiene. The care plan, dated 5/4/22 and last revised on 8/3/22, indicated the resident was at risk for falls related to a history of falls, poor safety awareness and decision making related to dementia. She would turn off or take off alarms and try to get up unassisted as times. The interventions included, but were not limited to ask therapy for a recommendation on an appropriate helmet (dated 9/23 and 9/24). A helmet was received (starting 9/27/22), and would implement use upon return (starting 10/11/22). The care plan, dated 5/8/22 and last revised on 10/31/22, indicated the resident was at risk for skin breakdown and UTI (urinary tract infections) due to impaired cognition, incontinence of bowel and bladder and requiring assistance and reminders to turn and reposition. On 10/29/22, the care plan was updated for the "Risk for skin breakdown related to the safety helmet and the suspected deep tissue injury of the right outer ear." The interventions included, but were not limited to observe the ears, chin, and jawline every shift for signs of breakdown (starting 10/31/22), observe the skin daily with care and notify the nurse, contact the MD/NP as needed for areas of concern, and document on the skin at least weekly (starting 5/8/22).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

The clinical record lacked documentation of the monitoring for skin impairment related to the soft helmet prior to the discovery of the deep tissue injury.

The clinical record lacked documentation of therapy notes related to an evaluation for the soft helmet size.

The physician's order, dated 10/11/22, indicated to encourage the wearing of the soft helmet every day and night shift for the fall risk.

The Initial Pressure Wound Assessment, dated 10/29/22, indicated a suspected deep tissue injury to the right outer ear, which measured 0.3 cm long by 0.2 cm wide. The treatment initiated was for the application of skin prep. The nursing staff were to monitor the skin integrity to the ears, jawline, and neck every shift related to the wearing of the soft helmet. A potential supply of another style of helmet was to be looked into, if available.

The physician's order, dated 10/29/22, indicated to monitor the skin integrity to the ears, neck, and jawline related to wearing the soft helmet. Notify the physician of any changes in the skin condition every day and night shift for skin integrity.

During an interview on 11/7/22 at 9:27 a.m., the Rehabilitation Manager indicated the facility asked her to measure for the soft helmet. She had to guess on the size, because the resident was in the hospital at that time. She just found a resident with a similar sized head and used that as a guide for the helmet fit. She was not told of the rubbing of the soft helmet on the resident's ear. The facility had not asked her to find a different

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

helmet. To properly fit a helmet, she would follow the guide book for ordering a helmet. She would measure the circumference of the head usually.

During an interview on 11/7/22 at 9:52 a.m., the Wound Nurse indicated nursing staff would do the daily skin assessments. She was told by a nurse of the discovery of the suspected deep tissue injury to the ear. Therapy was consulted for the soft helmet to prevent further head injuries. The resident was very demented and was unable to follow directions, and they had exhausted all interventions. She had assumed that therapy had fitted the helmet. She didn't feel the helmet was tight on the resident. The helmet had a strap under the chin. The order was for the resident to wear the helmet all of the time. The nurse or CNA (certified nurse aide) could put the helmet on the resident. She was unsure if another helmet would be ordered.

The Wound Management Program policy, dated 8/1/2018, was provided by the DON (Director of Nursing) on 11/1/22 at 10:00 a.m. The policy included, but was not limited to, "... A. Accountability 1. The Wound Management Program identifies staff participation and accountability to include: a. Persona responsible for program oversight and coordination. b. Staff involved in prevention and treatment (and their roles) c. Expectation of all caregivers to observe resident skin integrity during the daily provision of the resident's personal care during the daily provision of the resident's personal care..."

3.1-40(a)(1)
3.1-40(a)(2)