STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00346604. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00346604 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0686. Survey dates: February 8 and 9, 2021. Facility number: 013005 Provider number: 155816 AIM number: 201256400 Census Bed Type: SNF/NF: 17 SNF: 45 Residential: 6 Total: 68 Census Payor Type: Medicare: 36 Medicaid: 18 Other: 8 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on February 12, 2021	F 0000		
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			

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

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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	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 observation, interview and record review, the facility failed to assess and document weekly assessment of a resident's pressure ulcer, provide weekly skin observation and timely obtain an order for treatment of a pressure ulcer for 2 of 3 residents reviewed for pressure ulcers. (Resident B and C) Findings include: 1. The clinical record for Resident B was reviewed on 2/8/21 at 1:45 p.m. The diagnoses for Resident B included, but were not limited to, hemiplegia and hemiparesis. The 11/13/20 Quarterly MDS (Minimum Data Set) assessment indicated no brief interview for mental status was conducted as he was rarely or never understood. He required extensive assistive with bed mobility, toilet use, dressing and eating. He was totally dependent on staff for transfers, locomotion on and off the unit, and personal hygiene. He was at risk for pressure ulcers with no unhealed pressure ulcers and no other skin conditions at the time of the assessment. An observation of Resident B was made on 2/9/21 at 10:55 a.m. He was sitting in his wheel chair in	F 0686	**F 686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER** "Facility failed to assess and document weekly assessment of a resident's pressure ulcer, provide weekly skin observation and timely obtain an order for treatment of a pressure ulcer for 2 of 3 residents reviewed for pressure ulcers." (Resident B and C) It is the practice of this provider to provide care/services for highest well-being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** ·Resident B discharged on 1/21/2021. ·Resident C assessed for skin impairments. Wound treatment orders in place and weekly skin	03/05/2021

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	his room. He had pressure relieving boots on both feet. The November, 2020 TAR (treatment administration record) indicated an old skin impairment during his 11/7/20 and 11/21/20 skin assessments. An interview was conducted with the DNS (Director of Nursing Services) on 2/9/21 at 12:00 p.m. She indicated she was unsure what old skin impairment was being referenced in the November, 2020 assessments. The 11/21/20 assessment was completed by agency personell and she had no way of getting ahold of him. The 12/5/20, 5:48 a.m. progress note read, "CNA (Certified Nursing Assistant) informed this nurse that resident had a area on his left heel. Area 4cm x 4.6cm x 0cm. Area discolored redness to being black in part of the wound. Noted callus like tissue to 12am. Area unstageable. Skin prep ordered with also to float heel. Nutrition of G-T [g-tube] feeding 12 hours per day. H20 [water] flushes every 4 hours. Finger foods as tol [tolerated] during the day. NP [Nurse practitioner] notified. Will notify Emergency contact." The 12/9/20 pressure ulcer to heel care plan indicated approaches were to, "Assess and record the condition of the skin surrounding the pressure ulcer" and "Weekly skin assessment, measurement, and observation of the pressure ulcer and record." The Wound Management tool in the electronic health record indicated weekly wound assessments were completed on 12/9/20, 12/30/20, 1/6/21, 1/13/21, 1/20/21, and 1/27/21. There were no weekly assessments for the week of 12/16/20,		assessment order in place. Wound documentation up to date. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ·All residents with pressure wounds have the potential to be affected by the alleged deficient practice. ·DHS/designee to complete campus wide review of all residents with pressure wounds to ensure wound documentation complete and weekly skin assessments up to date by February 28, 2021. ·DHS/designee to complete campus wide review of all residents with pressure wounds to ensure treatment orders are in place by February 28, 2021. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ·The DHS/designee will conduct an in-service with licensed nursing staff regarding following guidelines for weekly skin assessments and wound care prevention and treatment by March 5, 2021. ·"Wound Care Prevention / Treatment" ·"Weekly Skin Assessments"	

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	12/23/20, or 2/3/20 in the tool or progress notes. An interview was conducted with the DNS on 2/8/21 at 3:15 p.m. She indicated pressure ulcers were to be assessed at least weekly and should be documented in the wound management tool or in a progress note. She and LPN (Licensed Practical Nurse) 3 were responsible for completing the weekly assessments. She did the 2/3/21 assessment, but had not yet documented it into the health record. She was going to look for the 12/16/20 and 12/23/20 wound assessments. On 2/9/21 at 10:30 a.m., the CNC (Clinical Nurse Consultant) provided an updated Wound Management tool from the electronic health record. There were wound assessments for 12/16/20, created on 2/9/21 at 7:14 a.m. and 2/3/21, created on 2/9/21 at 7:00 a.m. At this time, the DNS provided personal notes she had used to document the information now included in the tool for the 12/16/20 and 2/3/21 assessments. An interview was conducted with the DNS on 2/9/21 at 12:00 p.m. She indicated she was unable to locate verification of a wound assessment for 12/23/20. 2. The clinical record for Resident C was reviewed on 2/8/21 at 1:29 p.m. The Resident's diagnosis included, but were not limited to, aphasia and left hemiplegia. He was discharged to an acute care hospital on 1/21/21. A Quarterly MDS (Minimum Data Set) Assessment, completed 11/23/2020, indicated that Resident C was at risk for skin breakdown, and needed extensive assistance of 2 staff for bed mobility and toileting. A care plan, with a start date of 7/22/2019,		·As a measure of ongoing compliance, the DHS/designee will complete an audit twice weekly for 4 weeks, then weekly for 4 weeks, then continue weekly ongoing to ensure residents with pressure wounds treatment orders are in place and weekly skin assessments and weekly wound documentation are complete. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** ·For quality assurance, the DHS or designee will review any findings and subsequent corrective action at least quarterly in the campus quality assurance meeting. The plan will be revised, as warranted. **5. Date of completion:** March 5, 2021	

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	indicated He was at risk for skin breakdown related to the need for assist with all mobility and being incontinent with an intervention, dated 7/22/2019, to conduct weekly skin assessments. Paying particular attention to bony prominences. During an interview on 2/9/21 at 10:45 a.m., FM (Family Member) 1 indicated she was concerned about the condition of a wound on his bottom when it was found. The clinical record contained a wound event, dated 1/19/21, which indicated he had an intact fluid filled blister on his sacrum (tail bone). The clinical record did not contain a physician's order for a treatment to the sacrum until 1/21/21. A Physician's orders, dated 1/21/21, indicated that a CBC (Complete Blood Count) with Differential, CMP (Comprehensive Metabolic Panel), a prealbumin lab were to be drawn. Also, a sacrum and coccyx x-ray were to be completed. The Sacrum and Coccyx x ray results, dated 1/21/21, indicated a finding of the absence of the inferior coccyx and possible chronic coccygeal osteomyelitis (bone infection). The CBC results, dated 1/21/21, indicated he had an increased white blood cell count of 12.9, with normal range being 4.5 through 10.8. A Physician's progress note, dated 1/21/21, indicated he had been seen due to a sacral wound, which was noted to have a foul odor and was about the size of a half dollar, with slough (dead yellow tissue) present. Nursing reports undermining as well. He had a low-grade temperature of 99.3 degrees Fahrenheit, with mild			

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	tachycardia (high heart rate). He appeared to be becoming septic and was to be sent to the hospital for an osteomyelitis work up. The clinical record did not contain any progress notes indicating changes to the sacral wound from 1/19/21 through 1/21/21. The acute care hospital records contained a CT scan, completed 1/21/21, indicated Resident C had a sacral decubital ulcer with soft tissue extension down to the level of the bone and osseous erosions in the sacrum and coccyx. These findings are consistent with osteomyelitis. A physician's order, dated 7/2/2019, indicated that a weekly skin assessment was to be completed on the 2:20 p.m.to 10:30p.m. shift on Mondays. The January 2021 TAR (Treatment Administration Record) indicated that the weekly skin assessments had been completed on 1/18/21 the weekly skin assessment had been signed of as completed by QMA (Qualified Medication Aide) 1 and that there were no new or old skin areas. There was no addendum entry indicating that a nurse had completed the assessment. During an interview on 2/9/21 at 11:50 a.m., QMA 1 indicated she had let the nurse she was working will know that Resident C's skin assessment needed to be completed and signed off the weekly skin assessment as completed on the TAR. She had not completed the skin assessment because she was a QMA and was not able to do it. She did not recall if she had verified with the nurse that it was done. When a shift was "crazy" she sometimes did this so that it would not be left in red (indicating not completed).			

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	During an interview on 2/9/21 at 12:45 p.m., the CNC (Clinical Nurse Consultant) indicated that QMA's should not complete weekly skin assessment and that if a QMA signed a skin assessment off as completed, the nurse who completed it should make an addendum entry to indicate the nurse had done the assessment. The Pressure/Stasis/Diabetic Wound Guidelines policy was provided by the CNC on 2/9/21 at 10:30 a.m. It read, "PURPOSE: To provide weekly documentation of wound measurements and condition. PROCEDURES: 1. Appropriate skin Event is completed by a RN [Registered Nurse]/LPN in EHR [electronic health record.] a. Complete event for each impaired area. b. All measurements are recorded in centimeters. c. While active, event will remain open in EHR. 2. Document description of wound using: a. Length - 12 o'clock to 6 o'clock b. Width -3 o'clock to 9 o'clock c. Depth -deepest area of wound bed d. Exudates e. Color f. Odor g. Wound margins h. Surrounding tissue i. Tunneling and/or undermining if applicable 3. Document objective information about pain. 4. Re-assessment/measurement weekly or with significant change in wound noting the current treatment, medical interventions provided and comments as needed." On 2/9/21 at 12:45 p.m., the CNC provided the Guidelines for Weekly Skin Observation Policy, dated 1/7/2019, which read "...Purpose To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and /or treatment measures as indicated. Procedure 1. A full body observation shall be completed weekly by the licensed nurse...."			

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	This Federal tag relates to complaint IN00346604. 3.1-40			
R 0000 Bldg. 00	This visit was for a COVID-19 Walk Through Survey. Survey dates: February 8 and 9, 2021 Facility number: 013005 Residential Census: 6 Arlington Place was found to be in compliance with 410 IAC 16.2-5 in regard to the COVID-19 Walk Through Survey. Quality review completed on February 12, 2021	R 0000		