STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Park Nursing Center	650 Fairway Dr Evansville, IN 47710

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35733 Based on interview and record review, the facility failed to ensure a newly admitted resident had immediate orders for wounds for 1 of 3 residents reviewed for wounds. (Resident B) Finding includes: On 3/20/25 at 8:44 a.m., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemaparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction,chronic obstructive pulmonary disease, unspecified protein-calorie malnutrition, hyperlipidemia. An Admission Minimum Data Set (MDS) assessment dated [DATE], indicated Resident B's cognition was intact, range of motion, impairment one side upper and lower extremities. Pressure injury, 2 unstageable deep tissue injury present on admission. Resident B admitted to the facility on [DATE], discharged on [DATE]. Care plans included, but were not limited to: [Resident B] is at risk for skin breakdown or further skin breakdown due to refuses showers at times. Responds to verbal commands but can't always communicate discomfort or need to be turned. Or has some sensory impairment that limits ability to feel pain/discomfort in 1 or 2 extremities. Skin is kept moist almost constantly by perspiration, urine, etc. Ability to walk severely limited or nonexistent. Can't bear own weight and/or must be assisted into chair or wheelchair. Makes, frequent though slight, changes in body or extremity position independently. Eats over half of most meals. Eats a total of 4 servings of protein (meat and dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement when offered. Requires moderate to maximum assist in moving. During a move, skin probably slides to some extent, against sheets, chair, restraints or other device. Maintains relatively good position in chair or bed most of the time but occasionally slides down, start date 7/25/24, edited 11/4/24. Approaches included, but were not limited to: Assess and document skin condition weekly and as needed. Notify MD of abnormal findings, start 7/25/24 Preventative treatment as ordered, start 7/25/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident has bruise to right heel, start 7/26/24, d/c'd 7/30/24. Approaches included, but were not limited to: Document abnormal findings and notify MD, start 7/25/24, d/c'd 7/30/24 Observe for increase in size of bruise or development of new bruising, start date 7/26/24, d/c'd 7/30/24. Treatment as ordered, start 7/26/24, d/c'd 7/30/24. Resident has impaired skin integrity to: DTI (deep tissue injury) to right outer heel and bottom of left foot (bottom of left foot healed 8/23/24) start date 7/30/24. Approaches included, but were not limited to: Float heels while in bed, start 8/8/24. Pressure relieving boot when up in chair and during transfers, start 8/8/24. A progress note dated 7/25/24 at 6:45 p.m., indicated: Resident arrived to facility from hospital transportation vehicle via wheelchair. Resident placed into room [room number] placed in bed by facility staff x2 with gait belt. Resident alert and oriented to self only. V/S (vital signs) stable, afebrile. Incontinent of B&B (bowel and bladder). Resident presented with right sided weakness. Upon skin assessment this nurse observed a small bruise 1 cm x 1 cm to right lateral heel, abrasion on the right side of middle back 4cm (centimeters) x 3cm, and a non fluid filled previous blister that was calloused and dry. No family or visitors in at present. A admission observation report dated 7/25/24 included but was not limited to: Skin: .alterations in skin =yes Abrasion -right thoracic back, 4 cm length, 3 cm width Bruise- right heel, 1 cm length, 1 cm width Wound- left bottom of foot, length 11 cm, width 6 cm A wound assessment note dated 8/2/24 included but was not limited to: right heel- Length 1.50 cm, width 1.0 cm, depth 0.10, pressure, DTI left bottom of foot- length 11.20 cm, width 9.50 cm, depth 0.10 cm. pressure, DTI Physicians orders for July 2024 were reviewed and included but were not limited to: Apply skin prep to DTI on outer heel and to bottom of left foot, order date 7/30/24. On 3/21/25 at 10:58 a.m., RN 2 indicated when a skin assessment is done on a new resident admission, she documents what she sees, if sees a skin issue, notify's the physician and the the Assistant Director Of Nursing, there is a place on the admission assessment to put measurements. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/25 at 11:56 a.m., the DON indicated she and the IP nurse (Infection Prevention Nurse) both did Resident B's admission, they were both new at that time and learning, they assumed the area on the palm of left foot was an reabsorbed blister, it almost looked like he had stepped on something, there was a thick layer of skin. They thought the area on the right heel was a bruise, she now knows the policy, and typically will open a skin event on admission on any skin issue. Ob 3/21/25 at 2:40 p.m., the Regional Nurse Consultant provided the current policy on alterations in skin integrity/wound management policy with a revision date of 9/22. The policy included but was not limited to: It is the policy of [name] to ensure that each resident receives care, consistent with professional standards of practice, and receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection .All residents will be interviewed at admission, semiannually, and with significant change of condition about any impairment in skin integrity .1. Alterations in skin integrity will be reported to the MD/NP, the resident and/or resident representative. 2. A treatment order will be obtained from the MD/NP including order for third party if applicable 4. All newly identified areas after admission will be documented in the New Skin Event. 5. The Director of Nursing/Clinical Director/designee will be notified of alterations in skin integrity. a. The DON/CD/designee will complete further evaluation of the skin impairment identified and complete the appropriate skin evaluation on the next business day. The assessment may include measurements,staging, condition of tissue, and drainage. The assessment will be documented in the clinical record. 6. The DON/CD/designee will assess the area and complete an IDT (interdisciplinary team) initial wound review using the progress note template .Wound management : 1. Wound management for ulcers: any Stage 2 or greater pressure injuries; arterial, diabetic, venous ulcers; or suspected deep tissue injury will be referred to a third-party provider for care or the resident will be considered for referral to comprehensive care facility .2. Wound management for non-ulcers: bruises, skin tears, rashes, etc, will be assessed by the DON/CD/designee. If no signs of complications or worsening the skin event can be closed after 72 hours, and no further documentation is required . On 3/21/125 at 12:46 p.m., the DON provided the current policy on skin management with the latest date of 5/22. The policy included but was not limited to: It is the policy of [name] to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing . This citation relates to Complaint IN00455053. 3.1-30(a)