

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Yorktown Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S Andrews Rd Yorktown, IN 47396	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48146</p> <p>Based on record review and interview, the facility failed to promptly initiate wound treatment to promote healing of pressure injuries for 2 of 3 residents reviewed for pressure injuries. (Resident B and C).</p> <p>Findings include:</p> <p>1. Resident B's clinical record was reviewed on 6/10/24 at 9:45 a.m. Diagnoses included acute diastolic congestive heart failure, end stage renal disease, and pressure injury of right buttock, stage 3 (full thickness tissue loss).</p> <p>A Nursing Evaluation-(Admit/Readmit/Quarterly/COC), dated 3/14/24, indicated the resident had a skin tear to the sacrum measuring 6.0 centimeters (cm) length x 1.6 cm width x 0.1 cm depth, nearly the diameter of a tennis ball.</p> <p>An electronic mail (e-mail) message from the wound care company, dated 3/20/24 at 11:48 a.m. and provided by the DON, indicated Resident B was examined by the provider and had admitted to the facility with a pressure injury to the right buttock, stage 3.</p> <p>A Weekly Pressure Injury Evaluation, dated 3/20/24 at 1:53 p.m. indicated the resident admitted to the facility with a stage 3 right buttock pressure injury.</p> <p>A Wound Assessment Report, dated 3/20/24, indicated the resident admitted to the facility with a right buttock pressure injury, stage 3.</p> <p>A current care plan, initiated on 3/20/24, indicated the resident admitted to the facility with a stage 3 pressure injury to the right buttock.</p> <p>A physician's order, dated 3/20/24, indicated the following treatment to the sacrum: Cleanse with wound wash, dry. Apply skin prep to periwound. Apply collagen powder (to promote wound healing) to wound bed. Cover with hydrocolloid (to absorb drainage and promote healing) dressing, change three times a week and as needed.</p> <p>The clinical record lacked a physician's order for the treatment of Resident B's stage 3 pressure injury prior to 3/20/24, resulting in six days without treatment to the stage 3 pressure injury.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident C's clinical record was reviewed on 6/10/24 at 12:15 p.m. Diagnoses included fracture of one rib, left side, chronic kidney disease, stage 3 and unspecified hydronephrosis.</p> <p>A Nursing Evaluation (Admit/Readmit/Quarterly/COC), dated 5/31/24 at 2:10 p.m. lacked assessment of the resident's skin integrity.</p> <p>Review of a facility document titled, Wound nurse notification form, dated 5/31/24 and provided by the DON, indicated the resident admitted with a stage 3 pressure injury to the buttocks, measuring 4.0 cm length x 3.0 cm width x 0.1 cm depth, nearly the diameter of a golf ball.</p> <p>A Wound assessment report, dated 6/6/24, indicated Resident C admitted to the facility with a stage 3 pressure injury to the sacrum.</p> <p>A physician's order, dated 6/6/24, indicated to apply calmoseptine external ointment (a moisture barrier) to sacrum two times a day for wound care. Wash with soap and water, dry, then apply ointment.</p> <p>The clinical record lacked physician's order for the treatment of Resident C's stage 3 pressure ulcer prior to 6/6/24, resulting in seven days without treatment to the stage 3 pressure injury.</p> <p>A Weekly Pressure Injury Evaluation, dated 6/7/24 at 12:10 p.m., indicated the resident had a pressure injury on the sacrum at admission on 5/31/24.</p> <p>A current care plan, initiated on 6/7/24, indicated the resident admitted to the facility on [DATE] with a stage 3 pressure ulcer to the sacrum.</p> <p>During an interview, on 6/10/24 at 3:06 p.m., RN 2 indicated when a new admission or returning resident entered the facility, a skin assessment was completed as soon as possible. If the resident was noted to have skin issues, the staff documented on the wound nurse notification form which was blue in color and staff completed the appropriate online form.</p> <p>During an interview, on 6/11/24 at 10:57 a.m., the DON indicated the expectation for all new residents and returning residents was skin assessments were completed as soon as possible, but no later than 8 to 12 hours after arrival. Treatment orders for any skin issues, such as pressure injuries, were to be completed as soon as possible, but no more than 24 hours from discovery.</p> <p>During an interview, on 6/11/24 at 11:58 a.m., the DON indicated she was not able to locate treatment order for Resident B from 3/14/24 through 3/20/24 or for Resident C from 5/31/24 to 6/6/24. She indicated these time frames were outside the expectations for treatments orders to be initiated.</p> <p>A current facility policy, revised 9/22 and titled Skin and Wound Management System, provided by the Administrator on 6/10/24 at 1:42 p.m., indicated the following: . 1. An assessment of skin integrity is to be performed on each resident upon admission to the center by completing: a. A head-to-toe physical evaluation of the skin conditions .5. Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection</p> <p>This citation relates to Complaint IN00431698.</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-40(a)(2)