| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155274 | A. Building<br>B. Wing | 02/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waters of Rockport Skilled Nursing Facility, The | 815 W Washington St<br>Rockport, IN 47635 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>39130<br><br>Based on interview and record review, the facility failed to ensure services were provided to prevent the development of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. A resident's plan of care was not developed with interventions to prevent new pressure from developing after the resident was assessed to be at risk for pressure, and no documentation in the resident's record indicated the resident was turned or repositioned in accordance with physician orders. (Resident D)<br><br>Findings include:<br><br>During record review on 2/3/25 at 10:30 A.M., Resident D's diagnoses included, but were not limited to weakness, Parkinson's disease, unspecified abnormalities of gait and mobility, type 2 diabetes, dementia, and urge incontinence. Hospice started when? admitted ? discharge date ?<br><br>Resident D's most recent admission Minimum Data Set (MDS) assessment, dated 11/27/24, indicated the resident was admitted to the facility with one unhealed Stage I pressure ulcer. (According to the National Pressure Injury Advisory Panel [NPIAP], a Stage I pressure ulcer is defined as: The skin is intact with nonblanchable erythema.) Resident D had moderate cognitive impairment, utilized a wheelchair for mobility, was dependent on two staff for transfers, and required partial assistance to roll from right to left in bed.<br><br>A Braden scale assessment (tool used to predict the risk for developing pressure ulcers), completed 11/22/24, indicated Resident D was at low risk for developing pressure ulcers.<br><br>Resident D's physician orders included, but were not limited to, turn and reposition every two hours and as needed (started 11/23/24).<br><br>A Braden scale assessment, completed 11/30/24, indicated Resident D was at moderate risk for developing pressure injuries.<br><br>A weekly wound assessment note, dated 12/13/24, indicated Resident D had no skin impairment and no wounds.<br><br>Resident D's care plan included, but was not limited to, Skin integrity impairment (initiated 1/22/25) due to right heel and coccyx ulcer (revised 1/27/25).<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155274 | A. Building<br>B. Wing | 02/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waters of Rockport Skilled Nursing Facility, The | 815 W Washington St<br>Rockport, IN 47635 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident D's care plan did not include a focus on the resident's risk for developing pressure ulcers following the Braden scale assessment on 11/30/24, nor did it include interventions to prevent the development of pressure ulcers prior to 1/22/25.<br><br>Resident D's initial wound note dated 1/22/25 indicated Resident D had a new Stage II<br><br>wound to the right heel that measured 5 cm x 4 cm x 0.1 cm.<br><br>Resident D's progress notes included, but were not limited to:<br><br>1/23/25 at 1:17 P.M. - New pressure area noted to right heel on 1/22/25 by licensed nurse, during care.<br><br>1/25/25 at 12:49 P.M. - Resident has an area to the coccyx. A right-side blister measured 4.2 centimeters (cm)(length) x 6 cm (width). A left-side discolored area measured 4.9 cm x 4.3 cm.<br><br>1/28/25 at 3:31 P.M. - (Skin and wound note) - Resident was evaluated for a stage II pressure ulcer to right heel and an unstageable pressure ulcer to bilateral buttock. Education on the importance of frequent turns while in bed and frequent repositioning while in chair was provided. (According to the NPIAP a Stage II pressure ulcer is defined as: partial-thickness skin loss involving the epidermis and dermis. An unstageable pressure ulcer is obscured by slough or eschar which makes depth and extent of tissue damage unable to be determined.)<br><br>Resident D's wound assessment report, dated 1/28/25, indicated the following:<br><br>An unstageable pressure ulcer to the bilateral buttock measured 11 cm x 9.5 cm x 0.1 cm (depth). The wound bed was covered by 80% epithelial tissue and 20% slough. Peri wound was intact, fragile, macerated with edema and erythema (redness and swelling). A moderate amount of serosanguineous exudate was present.<br><br>A stage II pressure ulcer to the right heel measured 4.5 cm x 6 cm x 0.1 cm. The wound bed was covered by 100% epithelial tissue. Peri wound was intact, fragile, and dry. No drainage was present.<br><br>A review of Point of Care (POC) CNA charting for the month of January 2025 included documentation that Resident D had been turned and repositioned every two hours starting 1/27/25. No documentation of routine turning and repositioning was found in Resident D's record during the month of January 2025 prior to 1/27/25.<br><br>During an interview on 2/3/25 at 11:15 A.M., LPN 4 indicated she was working as an aide and that the CNA's should document routine turning and repositioning.<br><br>During an interview on 2/3/25 at 11:25 A.M., the Director of Nursing (DON) indicated that a change from low risk to moderate risk for developing pressure ulcers would typically trigger an update to the resident's care plan that would include interventions to prevent the development of pressure ulcers.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155274 | A. Building<br>B. Wing | 02/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waters of Rockport Skilled Nursing Facility, The | 815 W Washington St<br>Rockport, IN 47635 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/3/25 at 2:40 P.M., the DON supplied a facility policy titled, International Guideline (Prevention and Treatment Pressure Ulcers/Injuries: Clinical Practice Guidelines), dated 10/9/23. The policy included, .Risk Assessment - A risk Assessment is considered the starting point for prevention of pressure injury . an 'at risk' resident can develop a pressure injury within hours of the onset of pressure. For this reason, the 'at risk' resident must be identified, and have specific interventions put promptly in place and care planned in an effort to prevent formation of pressure injury . Positioning and Mobilization . Turn and reposition resident who are 'at risk' for pressure injury often unless contraindicated. At least every 2 (two) hours is recommended .<br><br>This citation relates to complaint IN00452313.<br><br>3.1-40(a)(2) |