

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Poplar Care Strategies		STREET ADDRESS, CITY, STATE, ZIP CODE 313 Poplar St Loogootee, IN 47553	

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>39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate care was provided to prevent and treat new pressure wounds for 2 of 3 residents reviewed for pressure wounds. Initial observations of deteriorating skin areas were not documented or communicated, initial wound care was not documented following the development of pressure wounds, and ordered treatments were not completed for pressure wounds. (Resident D, Resident F)</p> <p>Findings include:</p> <p>1. During an interview on 2/18/25 at 10:30 A.M., QMA 4 indicated that Resident D had multiple wounds.</p> <p>During an observation and interview on 2/18/25 at 3:30 P.M., Resident D was lying in bed with heel protector boots on each foot. Resident D indicated there were wounds on her feet and coccyx.</p> <p>Resident D's record review indicated the resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis, type II diabetes, need for assistance with personal care, obesity, and neurofunctional disorder of bladder.</p> <p>Resident D's most recent admission Minimum Data Set (MDS) assessment, dated 12/20/24, indicated the resident was cognitively intact, no functional abilities were assessed, had no unhealed pressure wounds, was at risk for pressure wounds, had an indwelling catheter, and was frequently incontinent of bowel.</p> <p>Resident D's initial Braden Scale assessment, dated 12/13/24, indicated the resident was at risk for developing pressure injuries.</p> <p>Resident D's nurse's progress notes included, but were not limited to:</p> <p>1/5/25 at 2:39 P.M. - Resident had 1 cm (centimeter) (length) x 1 cm (width) round open area on left gluteal fold of buttocks. A new treatment order was received.</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>1/12/25 at 12:30 P.M. - During resident's shower, some dry dressings on resident's left foot were observed and removed. A 3 cm x 2 cm deep tissue area on left heel. A left lateral foot deep tissue area that measured 1 cm x 1 cm and a left ankle deep tissue injury that measured 1 cm by 1 cm was observed. The Director of Nursing (DON) was notified. (A deep tissue injury is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear)</p> <p>2/9/25 at 12:07 P.M. - Open area noted to resident's coccyx area that measured 1 cm x 0.5 cm. The DON was notified.</p> <p>Resident D's care plan included, but was not limited to; resident has deep tissue area to left heel, left lateral foot, and left ankle due to immobility and diabetes (initiated 1/12/25), resident has actual impairment to skin integrity caused by friction to left gluteal fold (initiated 1/15/25), and resident has an activity of daily living (ADL) self-care performance deficit due to activity intolerance, hemiplegia and limited mobility (initiated 1/15/25). An intervention included, administer treatments as ordered (initiated 1/15/25).</p> <p>No care plan to prevent the development of pressure wounds following the Braden Scale assessment on 12/13/24 was in place.</p> <p>No care plan for the treatment of the wound first observed on 1/5/25 to the gluteal fold was initiated prior to 1/15/25.</p> <p>Resident D's physician orders included, but were not limited to; peri-care twice daily and as needed during day and night shift (started 12/22/24), cleanse open area to left distal buttock with normal saline, apply MediHoney and cover with protective foam dressing every night and as needed (started 1/5/25), Betadine applied to deep tissue areas on left heel, left lateral foot and left ankle twice a day (started 1/12/25), and apply MediHoney to wound on left outer ankle twice a day and cover with non-adherent pad and secure with Kerlix (gauze bandage roll) (initiated 1/17/25).</p> <p>Resident D's Treatment Administration record during January 2025 indicated that treatment orders; cleanse open area to left distal buttock with normal saline, apply MediHoney and cover with protective foam dressing every night and as needed (started 1/5/25).</p> <p>The treatment was not completed on 1/18/25 and 1/23/25 due to the resident was asleep.</p> <p>The treatment order Betadine applied to deep tissue areas on left heel, left lateral foot and left ankle twice a day (started 1/12/25) was not completed 1/19/25, 1/23/25, and 1/24/25 due to the resident was asleep.</p> <p>The treatment order apply MediHoney to wound on left outer ankle twice a day and cover with non-adherent pad and secure with Kerlix (initiated 1/17/25).</p> <p>The treatment was not completed 1/18/25 and 1/23/25 due to the resident was asleep.</p> <p>Resident D's documented weekly wound assessments included:</p> <p>1/5/25 - in house acquired, open lesion to left distal gluteal fold measured 1 cm x 1 cm</p> <p>(continued on next page)</p>		

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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>1/12/25 - in house acquired, open lesion to left distal gluteal fold measured 1 cm x 1 cm, in house acquired, left heel unstageable pressure ulcer measured 3 cm x 2 cm, in house acquired, left lateral foot unstageable pressure ulcer measured 1 cm x 1 cm, and in house acquired, left ankle unstageable pressure ulcer measured 1 cm x 11 cm. (Unstageable Pressure wound is a full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore stage, cannot be determined.)</p> <p>1/17/25 - in house acquired, open lesion to left distal gluteal fold measured 1 cm x 1 cm, in house acquired, left heel unstageable pressure ulcer measured 3 cm x 2 cm, in house acquired, left lateral foot unstageable pressure ulcer measured 1 cm x 1 cm, and in house acquired, left ankle unstageable pressure ulcer measured 3 cm x 3 cm.</p> <p>1/24/25 - in house acquired, open lesion to left distal gluteal fold measured 1 cm x 1 cm, in house acquired, left heel unstageable pressure ulcer measured 3 cm x 2 cm, in house acquired, left lateral foot unstageable pressure ulcer measured 1 cm x 1 cm, and in house acquired, left ankle unstageable pressure ulcer measured 3 cm x 3 cm.</p> <p>1/31/25 - in house acquired, open lesion to left distal gluteal fold measured 0.5 cm x 0.5 cm, in house acquired, left heel unstageable pressure ulcer measured 2 cm x 2 cm, in house acquired, left lateral foot unstageable pressure ulcer measured 1 cm x 1 cm, and in house acquired, left ankle unstageable pressure ulcer measured 2 cm x 2 cm.</p> <p>2/6/25 - in house acquired, open lesion to left distal gluteal fold measured 0.5 cm x 0.5 cm, in house acquired, left heel unstageable pressure ulcer measured 2 cm x 2 cm, in house acquired, left lateral foot unstageable pressure ulcer measured 1 cm x 1 cm, and in house acquired, left ankle unstageable pressure ulcer measured 2 cm x 2 cm.</p> <p>2/13/25 - in house acquired, open lesion to left distal gluteal fold measured 4.5 cm x 3 cm x 0.1 cm, in house acquired, left heel unstageable pressure ulcer measured 2 cm x 2 cm, in house acquired, left lateral foot unstageable pressure ulcer measured 1.5 cm x 1.5 cm, in house acquired, left ankle unstageable pressure ulcer measured 1 cm x 1.1 cm x 0.1 (depth), and in house acquired shearing injury to the right gluteus measured 4 cm x 3.5 cm x 0.1 cm.</p> <p>During an interview on 2/19/25 at 10:30 A.M., LPN 4 indicated on 1/12/25, a skin check was being completed on Resident D when border foam dressings were observed on the resident's left ankle. LPN 4 indicated that a CNA was instructed to remove the dressings as Resident D did not have wound orders for the left ankle. Three wounds were then observed by LPN 4. LPN 4 indicated being unaware of the wounds prior to observing them on 1/12/24. LPN 4 then completed a wound assessment and notified the DON.</p> <p>During an interview on 2/19/25 at 12:50 P.M., LPN 4 indicated a resident being asleep would not be an appropriate reason to not complete a routine ordered wound treatment and further indicated that staff should complete routine checks and incontinent care at night which would be a good time to complete a wound treatment.</p> <p>(continued on next page)</p>		

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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>During an interview on 2/19/25 at 1:15 P.M., the DON indicated routine wound treatments should be completed as ordered and charting that a resident was asleep during the shift is not an appropriate reason for not completing wound care treatments.</p> <p>2. Resident F's record review indicated the resident's diagnoses included, but were not limited to, neurocognitive disorder, protein-calorie malnutrition, and anemia.</p> <p>Resident F's most recent admission Minimum Data Set (MDS) assessment, dated 12/18/24, indicated the resident was cognitively intact, was frequently incontinent of urine and occasionally incontinent of bowel. The resident required substantial assistance/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for rolling right to left while lying in bed and for lying to sitting on the side of the bed. Resident did not have a pressure ulcer/injury, had no unhealed pressure wounds, and was at risk for pressure wounds.</p> <p>Resident F's initial Braden Scale assessment, dated 12/11/24, indicated the resident was at risk for developing pressure injuries.</p> <p>A skin check, dated 12/11/24, indicated Resident F had a slightly pink area the coccyx that was present on admission.</p> <p>Resident F's care plan included, but was not limited to; at risk for impairment to skin integrity due to fracture of right femur/hip/sacrum/vertebra, Parkinson's disease, Lewy body dementia, hypothyroid, pulmonary embolism, protein malnutrition, anemia, depression, bilateral hearing loss, and history of cerebral infarction (initiated 12/13/24).</p> <p>Interventions included, follow facility protocols for treatment of injury and monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to the physician.</p> <p>Resident F's nurse's progress notes included, but were not limited to, a note by LPN 4 on 12/26/24 at 1:27 P. M., that indicated a border foam dressing was noticed on the coccyx area and removed. A 4 cm x 2 cm open area was observed. The area was cleansed with normal saline, protective dressing applied, and the DON was notified.</p> <p>Resident F's physician orders included, but were not limited to; cleanse wound on coccyx with normal saline, skin prep peri-wound, apply ColActive (collagen-based wound dressing that helps heal wounds) to wound, cover with border foam for protection daily (started 12/31/24).</p> <p>Resident F's Treatment Administration record during December 2024 contained no documentation that a wound treatment was ordered or administered to the resident's coccyx prior to 12/31/24.</p> <p>Resident F's documented weekly wound assessments included:</p> <p>(continued on next page)</p>		

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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>12/27/24 - Coccyx wound present on admission at a Stage I pressure wound. Area worsened to a Stage II pressure wound with the wound bed covered by 50 percent (%) granulation tissue and 50 % slough tissue with a moderate amount of serosanguinous drainage present and measured 4 cm x 2 cm x 1 cm. (A Stage I pressure wound is intact skin with non-blanchable redness of a localized area usually over a bony prominence. A Stage II pressure wound is partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. A Stage III pressure wound is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.)</p> <p>1/4/25 - Coccyx stage II pressure wound worsening with the wound bed covered by 25% granulation tissue and 75% slough tissue with serosanguinous drainage present and measured 3 cm x 3 cm x 1 cm. Peri-wound skin appeared more red and irritated.</p> <p>During an interview on 2/19/25 at 10:25 A.M., LPN 4 indicated completing Resident F's initial admission skin assessment and noted that a pink area to the resident's coccyx was blanchable and for that reason was not a staged wound and the area was not initially measured. On 12/26/24, LPN 4 was notified by CNA 8 that Resident F had a border foam dressing the coccyx. LPN 4 was not aware that the resident had a treatment order to the coccyx and removed the bordered dressing to observe an open area to the coccyx. LPN 4 indicated after asking about the wound, it was said that a CNA had observed Resident F's coccyx to have had a reddened area and was told to put a dressing on it. LPN 4 indicated no communication had been made to alert nursing or CNA 8 that Resident F had a reddened area and there had been no documentation in the resident's record of a worsening area to the coccyx. LPN 4 indicated nursing staff should document any changes in skin condition and notify the DON.</p> <p>On 2/19/25 at 1:30 P.M., the DON supplied two facility policies titled, Prevention of Pressure Injuries dated 4/2020, and Wound Care dated, 10/2010. The Prevention of Pressure Injuries policy indicated, .Monitoring 1. Evaluate, report and document potential changes in the skin. The Wound Care policy indicated, Documentation . The following information should be documented in the resident's medical record: 1. The type of wound care given 2. The date and time of the wound care was given .</p> <p>This citation relates to complaint IN00453477.</p> <p>3.1-40(a)(1)</p> <p>3.1-40(a)(2)</p>		