STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155386	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Dekalb	520 W Liberty St Butler, IN 46721

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on observation, interview and record review, the facility failed to ensure physician orders were obtained and followed regarding dressing changes for 1 of 7 residents reviewed (Resident 74). Findings include: On 9/3/24 at 9:07 AM, Resident 74 was observed with a dressing on their left below the knee amputation site. The date on the dressing was observed to be 8/22/24. In an interview on 9/3/24 at 9:09AM, Certified Nurse Aide (CNA) 25 indicated they observed the date on the dressing as 8/22/24. CNA 25 indicated they did not normally work on Resident 74's hall and had not been made aware of the dressing. In an interview on 9/3/24 at 9:19 AM, the Director of Nursing (DON) indicated the foam dressing to Resident 74's left leg amputation was most likely applied as a preventative measure to avoid injury. The DON indicated the skin under the dressing would have been inspected during weekly skin assessments. The DON indicated although the weekly skin assessments did not address specific areas of the body, the entire body was assessed. The DON indicated they did not believe the same dressing, dated 8/22/24, would have been reapplied after the dressing was removed to inspect the skin underneath. Resident 74's record was reviewed on 9/3/24 at 9:39 AM. Diagnoses included diabetes, peripheral vascular disease (poor blood circulation) and left below the knee amputation. Resident 74's Admission Minimum Data Set (MDS) dated [DATE] indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 (no cognitive impairment). The MDS indicated Resident 74 had a left below the knee amputation surgical incision. The MDS indicated the resident required orthopedic surgical wound care. The MDS indicated Resident 74 was participating in occupational and physical therapy 5 times a week. The MDS indicated Resident 74 was being administered insulin, a blood thinner and antibiotics. A physician order, dated 7/24/24, indicated the wound care practitioner was to evaluate and treat Resident 74 as indicated. A physician order, dated 7/26/24, indicated Resident 74 was to be administered doxycycline (antibiotic) 2 times a day for 14 doses for left below the knee amputation infection. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 7/26/24, indicated Resident 74 was to be administered cephalexin (antibiotic) every 6 hours for 28 doses for left below the knee amputation infection. A physician order, dated 7/26/24, indicated Resident 74's dressing to their left leg was to be left in place until their orthopedic appointment on 8/13/24. Resident 74's physician orders did not include a current or discontinued order for dressing changes of a baby soap cleanse, pat dry, silver infused foam and a tubular compression bandage every Monday, Wednesday and Friday. Resident 74's Care Plan, dated 7/27/24, indicated the resident had a risk for impaired skin integrity related to impaired mobility, diabetes, weakness, incontinence and the use of an indwelling urinary catheter. The target goal was to minimize risk through 11/16/24. Interventions included weekly head to toe skin assessments, observe dressing frequently and refer to actual impaired skin integrity (left below the knee amputation) plan of care. Resident 74's Care Plan, dated 7/27/24, indicated the resident had a risk for complications from their left below the knee amputation incision. The target goal was for the incision to heal without complications through 11/16/24. Interventions included observance of temperature elevation of the resident and observance of swelling, increased drainage, redness, warmth or odor of the incision. Resident 74's Care Plan did not include interventions for Steri-Strips or a prophylactic dressing to their left below the knee amputation incision. An Orthopedic Clinical Visit Summary, dated 8/14/24, indicated staples were removed from Resident 74's left below the knee amputation incision. A Skilled Care Note, dated 8/16/24, indicated Resident 74's left blow the knee amputation incision was open to air with Ster-Strips in place. Resident 74's physician orders did not include a current or discontinued order for Steri-Strips. A Wound Care Consult, dated 8/19/24, indicated Resident 74 had been evaluated for a non-healing wound of their left below the knee amputation after dehiscence (separation of edges) of their incision. The wound bed was debrided mechanically to remove a small scab. A Center for Wound Healing After Visit Summary, dated 8/19/24, indicated Resident 74's wound was to be cleansed with baby soap and water, patted dry, covered with a silver infused foam dressing and secured with an elastic tubular bandage every Monday, Wednesday and Friday. Resident 74 was to follow up with the facility wound care practitioner unless the wound became worse. In an interview on 9/4/24 at 9:40 AM, the DON provided a handwritten Wound and Skin Record for Resident 74. The DON indicated Wound and Skin records were kept in a book at the nurse station and scanned into the resident's electronic medical record later. Resident 74's Wound and Skin Record entries were as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/24, Resident 74 had a surgical wound to their left below the knee amputation. The dressing was to remain in place until their follow up orthopedic appointment on 8/14/24. On 8/1/24, Resident 74's dressing was intact. On 8/8/24, Resident 74's dressing was intact. On 8/14/24, Resident 74's incision measured 14 centimeters (cm) long and 3.5 cm wide, the incision was pink, well approximated with scattered scabs and Steri-Strips (adhesive wound closure) were intact. On 8/15/24, Resident 74's incision measured 14 centimeters (cm) long and 3.5 cm wide, the incision was pink with scattered scabs and Steri-Strips (adhesive wound closure) were intact. On 8/22/24, Resident 74's incision measured 14 centimeters (cm) long and 1 cm wide, the incision was pink, well approximated with small scabs. On 8/29/24, indicated Resident 74's incision measured 12 centimeters (cm) long and 1 cm wide, the incision was pink, and a prophylactic dressing was applied. In an interview on 9/4/24 at 1:20 PM, the DON indicated the dressing to Resident 74's left leg incision should not have been in place for 12 days. The DON indicated the foam dressing should be changed every 3 to 5 days and as needed. The DON indicated they were not aware of why the dressing was applied. The DON indicated a physician order for the dressing should have been obtained and the dressing application should have been documented. A current facility policy, dated 8/14/24, provided on 9/3/24 at 10:38 AM by the DON indicated residents admitted to the facility with any skin impairment would be provided with the following: -A physician order for treatment -Documentation of the location, measurements and characteristics of the wound -Appropriate interventions to promote wound healing -Preventative treatments would be documented in the care plan The policy indicated a licensed nurse would document preventative measures on the care plan and Kardex (summary of care plan). The policy indicated a licensed nurse would evaluate and document the condition of the dressing, the condition of the surrounding skin and pain in the resident's medical record. A current facility policy, dated 10/20/23, provided on 9/3/24 at 10:51 AM by the DON indicated the facility would obtain physician orders to ensure concise direction for the care of residents. 3.1-37

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review the facility failed to ensure a nasogastric (ng) tube was trreated according to physician orders for 1 of 1 resident reviewed (Resident 24). Findings include: During an observation and interview on 8/28/24 at 11:21 AM, Resident 24 indicated she had an ng tube placed for nutrition because she was unable to eat due to a worsening hiatal hernia. An ng tube was present in Resident 24's left nostril with tubing attached to a container of Jevity (a nutritional formula for tube feedings). Resident 24's record was reviewed on 9/3/24 at 10:24 AM. Diagnoses included dysphagia, pharyngeal phase, gastro-esophageal reflux disease without esophagitis, and pulmonary hypertension. Resident 24's current significant change Minimum Data Set (MDS) dated [DATE] indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). Resident 24's current care plan titled .unable to tolerate nutritionally adequate food or fluid .indicated the resident had a problem of a need for an ng tube for nutrition and hydration, with a goal date of 12/1/24. Interventions included tube dysfunction, or malfunction should be reported to the provider. Current physician orders did not include specific orders for managing blockages in the tubing. Progress notes dated 8/24/24 at 10:29 PM indicated staff were unable to administer Jevity due to a blockage of the tubing. The note indicated Nurse Practitioner (NP) 4 had given orders to send Resident 24 to the hospital. Progress notes dated 8/31/24 at 12:10 PM indicated the ng tube had become blocked after medication administration and Registered Nurse 2 had used Coke (a carbonated beverage) to unblock the tube. The note indicated lab reports were sent to the Nurse Practitioner. No other reports to the NP were recorded in this progress note. In an interview on 9/3/24 at 11:59 AM, the Director of Nursing (DON) indicated the facility did not have a policy for ng tube maintenance and care. She indicated when a policy was not available, staff should refer to [NAME] best practices. In an interview on 9/4/24 at 9:48 AM, the DON indicated the nurse should have contacted the NP for orders when she discovered the ng tube was blocked and should not have used Coke to unclog the ng tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lippincott Nursing Center best practice, Nursing 2024, Volume: 48 Number 6, page 66 indicated juices, or carbonated beverages can worsen an occlusion by causing proteins in the formula to precipitate within the tube. The recommended method was pulling back on a syringe plunger and then gently injecting warm water and moving the plunger back and forth to loosen the blockage and clamping the tube to allow the water to loosen the blockage. Additional methods required specific provider orders. 3.1-44(a)(2)