STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare	705 E Main St Centerville, IN 47330

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 28309 Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for pressure ulcers received the care and services required to treat the identified wound and documented the status of the wound routinely. (Resident B) Findings include: The clinical record of Resident B was reviewed on 2-10-25 at 11:02 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) with a dependency on supplemental oxygen, a history of TIA's (transient ischemic attacks or mini strokes), opioid abuse in remission, anxiety, polyneuropathy, hypertension, peripheral vascular disease and vascular dementia. His Admission Minimum Data Set (MDS) assessment, dated 12-16-24, indicated Resident B was admitted to the facility with one unstageable pressure ulcer. In a telephone interview on 2-10-25 at 10:30 a.m., with a family member of Resident B, she indicated the skin issue to the coccyx area developed while he was at home, prior to going to an area hospital and then to the facility. A review of Resident B's nursing progress notes, dated 12-7-24, indicated he was admitted with a skin issue to his coccyx which measured 8 centimeters (cm) by 7 cm and described as black in color. A notation, dated 12-9-24, from the wound care team, identified the area to the coccyx as an unstageable sacral pressure ulcer . Wound bed with 100% eschar [a hardened, dry black or brown scab-like area] tissue. The unstageable pressure ulcer was measured at 6.5 cm (length) by 6.5 cm (width) by 0.1 cm (depth), was noted to have no odor present, with the wound base 100% eschar, 0% granulation, 0% slough, 0% epithelial. It was described as causing no pain to the resident, had no drainage and the surrounding tissue of the wound was fragile. The wound care team's recommendations for care, dated 12-9-24, included, but were not limited to, Recommend betadine moistened gauze with foam drsg [dressing], change daily and prn [as needed]. This treatment was included on the Treatment Administration Record (TAR) for Resident B without a start date and was not marked to indicate the treatment had been provided until 12-11-24. The TAR failed to identify any treatments provided between 12-7-24 and 12-11-24, for the pressure ulcer, with the exception of a nursing progress notation, dated 12-7-24, of an abd pad [large gauze dressing] covering the pressure ulcer. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the nursing progress notes and Daily Skilled Notes, for Resident B, failed to routinely document any assessment of the wound, as follows: -An absence of progress notes or Daily Skilled Notes, on 12-8-24 and 12-9-24 to address the status of the pressure area. -On 12-10-24, 12-11-24, 12-12-24, 12-13-24 and 12-14-24, the Daily Skilled Notes, indicated Resident B had no skin concerns and received no skilled nursing services related to wound care. -On 12-21-24 and 12-22-24, the Daily Skilled Notes, indicated Resident B had no new skin concerns, but received skilled nursing services related to wound care. -On 12-23-24 and 12-24-24, the Daily Skilled Notes, indicated Resident B had no skin concerns, but received skilled nursing services related to wound care. In an interview with the Director of Nursing (DON) on 2-10-25 at 5:10 p.m., she indicated the skilled nursing notes can be in the form of a progress note or the Daily Skilled Note. She indicated under the Daily Skilled Note, Section L, should identify all skilled services that are being provided to the resident, such as wound care or pressure ulcer care management. She added this particular document was fairly new to the facility and there has not been any formal training for how to properly complete the document. The DON indicated it looked like, to her, the resident was admitted to the facility, on 12-7-24, and the wound to the sacrum was identified at that time. The DON indicated she would have liked to see more detailed documentation about what care was provided and what the wound looked like between the admission note and when the wound team saw the resident, on 12-9-24. On 2-10-25 at 5:25 p.m., the DON provided a copy of a policy entitled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, with a revision date of March 2014. This policy indicated, Assessment and Recognition .the nurse shall describe and document/report the following: Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; Pain assessment; Resident's mobility status; Current treatments, including support surfaces and; All active diagnoses. The staff will examine the skin of a new admission for ulcerations or altercations in skin. The physician will assist the staff to determine etiology (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of the skin altercation .The physician will authorize pertinent orders related to wound treatments, including wound cleansing and abridgement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents if indicated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2-10-25 at 5:25 p.m., the DON provided an undated copy of a policy entitled, Charting and Documentation. This policy indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record: Objective observations; Medications administered; Treatments or services performed; Changes in the resident's condition; Progress toward or changes in the care plan goals and objectives .Documentation of procedures and treatments will include care-specific details, including: The date and time the procedure/treatment was provided; The name and title of the individual(s) who provided the care; The assessment data and/or any unusual findings obtained during the procedure/treatment; How the resident tolerated the procedure/treatment; Whether the resident refused the procedure/treatment; Notification of family, physician or other staff, if indicated; and The signature and title of the individual documenting. This citation relates to Complaint IN00451390. 3.1-40(a)(2)