STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Grove	31869 Chicago Trail New Carlisle, IN 46552

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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 31719 Based on interview and record review, the facility failed to prevent unstageable pressure ulcers from developing and failed to provide necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing on the bilateral heels of a resident who was admitted without pressure ulcers, for 1 of 3 residents review for pressure ulcers. (Resident C) This deficient practice resulted in the development of a facility-acquired Deep Tissue Injury (DTI) on the left heel that deteriorated to an unstageable pressure injury and the development of a facility-acquired Deep Tissue Injury (DTI) and DTI on the right heel that deteriorated to a stage three pressure injury with signs and symptoms of infection and required debridement. Findings include: The record for Resident C was reviewed on 6/28/2024 at 12:05 P.M. Diagnoses include, but were not limited to, multiple sclerosis (MS), edema, neuropathy, and hypertension A Quarterly Minimum Data Set (MDS) Assessment, dated 3/1/2024, indicated the resident was cognitively intact, had bilateral lower extremity impairment, and required substantial staff assistance for transfer and bed mobility needs. The assessment indicated the resident was at risk to develop pressure ulcers, but did not have pressure ulcers or impaired skin. A Braden Scale assessment (tool used for predicting pressure ulcer development risk), dated 5/14/2024, indicated the resident was at moderate risk for developing a pressure ulcer. A Care Plan, dated 2/20/24, indicated the resident was at risk for a pressure ulcer/skin breakdown due to her diagnoses of neuropathy and multiple sclerosis (MS). The interventions included, but were not limited to, observe skin daily for breakdown, complete a Braden Scale assessment per the facility's policy, diet as ordered, supplements as ordered, heel protectors to the resident's bilateral feet every shift, and moisturize her heels per the physician's order daily. A Nursing Progress Note, dated 4/21/2024 at 2:43 P.M., written by LPN 3, indicated the following, .Dark purple, intact areas found to bilat [bilateral] heels, with Right measuring 2.5 x 3.5 and L [left] measuring 2.0 x 1.0 (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 - Actual harm Residents Affected - Few	The CDC (Centers for Disease Control and Prevention) Pocket Guide to Pressure Wounds indicated, Deep Tissue Injury (DTI) pressure ulcers are defined as purple or maroon localized areas of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The Nursing Progress Note, dated 4/21/24, indicated a physician's order was received for skin prep to the resident's bilateral heels The Treatment Administration Record (TAR) for April 2024 indicated a physician's order was received, on 4/21/24, for skin prep to bilateral heels, every shift. The treatment documentation indicated the treatment started on 4/22/24. The April TAR continued the previous preventative measures of heel protector boots and a turn/reposition intervention every two hours. A Nurse Practitioner's (NP) Progress Note, dated 4/29/24 at 4:52 P.M., indicated there was a face-to-face visit with the resident conducted. The NP documented the resident had 1+(swelling that stays pitted when pressed for 1 second) ankle edema, was negative for ulceration during the foot exam, and the resident had no new concerns. There was no explanation provided regarding the lack of assessment and documentation of the DTI to Resident C's right and left heels. A Skin Evaluation Form, dated 4/30/24 at 1:30 P.M., indicated the resident's right heel had a hard dark closed area on her heel which measured 2.5 x 3.0 cm (centimeters). The tissue type was marked as necrotic/eschar. According to the Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System, copyright 2016, an unstageable pressure wound is defined as a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough [yellow, tan, gray, green, or brown matter covering the wound bed] and/or eschar [a hardened, dry black or brown colored dead tissue that forms a scab-like covering over deep wounds, such as burns or ulcers]. A Skin Evaluation Form, dated 4/30/24 at 1:31 P.M., indicated the resident's left heel had a dark closed area to heel, which measured 2.0 x 2.8 cm. The issue type was marked necrotic/eschar. A Dietary Note, dated 5/13/24 at 10:55 A.M., indicated the resident's skin was free of pressure areas, the resident had no noted edema and was well nourished. The note indicated the following: .Appears nutritionally adequate with current intakes at this time. No new recommendations. Continue with current interventions . Will continue to monitor There was no explanation provided regarding the lack of recognition of new pressure ulcer development for Resident C. A Monthly NP Follow up Note, dated 5/2/24, indicated the resident denied any complaints of pain or discomfort and .Spoke with nursing who stated member is currently at baseline with no new concerns. Chart reviewed and member is compliant with medication and care regimen The note did not include any documentation indicating the NP was aware of the resident's unstageable pressure injuries on her bilateral heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Minimum Data Set (MDS) assessment, completed as an annual review, on 5/17/2024, indicated Resident C was cognitively intact, had impaired mobility to her bilateral lower extremities, and had a Stage II pressure ulcer (partial thickness loss of the dermis skin layer with a shallow open wound). The assessment did not accurately reflect the multiple unstageable pressure ulcer wounds. A Skin Evaluation Form, dated 5/17/24 at 10:35 A.M., indicated the resident's left heel had a dark closed area to heel, which measured 2.0 x 3.0 cm. The issue type was marked as necrotic/eschar. A Skin Evaluation Form, dated 5/17/24 at 10:36 A.M., indicated the resident's right heel had a pressure injury with part of eschar to R heel has come off. The wound measured 2.0 cm in length x 2.8 cm in width x 0.1 cm in depth. There was no further description of the exposed wound bed, periwound (skin immediately surrounding the wound) or any signs of infection noted on the form. A NP Progress Note, dated 5/17/24, indicated the NP examined the resident and the resident had an open wound to the right posterior heel, with 2+ (swelling that stays pitted for up to two seconds when pressed) swelling, slough (dead tissue that has separated from living tissue) and was foul-smelling. The NP indicated the wound was a Stage II pressure wound and measured 4.0 cm. The plan was to have a wound culture obtained and wound care, with Santyl (a treatment to remove damaged tissue from wounds) daily. A Physician's Order, dated 5/17/24, indicated .Culture R heel wound .Santyl 250 unit/gram topical ointment . Everyday Cleanse R heel with wound wash, apply Santyl to R heel wound cover The order did not include documentation related to the facility-acquired DTI on the left heel and did not include documentation to indicate complete pressure relief should be provided to the bilateral heels. A Nursing Progress Note, dated 5/17/24 at 1:26 P.M., indicated the wound culture was canceled and culture swabs were ordered. The Treatment Administration Record (TAR) for May 2024 indicated Santyl wound treatment was documented from 5/18/24 through 5/23/24. A Skin Evaluation Form, dated 5/20/24 at 11:31 A.M., indicated pressure area to right heel, Stage III (full dermis skin loss with adipose tissue exposed but no bone, muscle or tendons exposed), which measured 2.0 cm length x 2.5 cm width x 0.1 cm depth. The form indicated the wound edges were irregular, attached with no undermining and necrotic/eschar was documented. A Nursing Progress Note, dated 5/20/24 at 11:36 A.M., indicated the resident was seen by the wound nurse in regards to a Stage 3 pressure area to the resident's right heel. The note indicated the facility NP had ordered a culture to be completed, on 5/17/2024, but the facility was waiting for wound culture supplies to be delivered. The resident was encouraged and re-educated regarding the importance of wearing pressure reducing boots while she was in bed, and off-loading her heels. The resident verbalized understanding. The nurse applied a knitted heel protector to the resident's left heel for preventative measure. Resident C stated That is more tolerable than those big boots. CNA staff were made aware of the need to apply boots/or knitted heel protectors to the resident's feet while she was in bed or in the recliner. Treatments were completed as ordered. The resident denied any pain to the open area upon assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Skin Evaluation Form, dated 5/21/24 at 2:58 PM., indicated the resident's left heel had a dark closed area to heel, which measured 2.0 x 3.0 cm. The issue type was marked necrotic/eschar. A Nursing Progress Note, dated 5/21/24 at 11:09 A.M., indicated a Care Plan meeting was conducted with the resident's family member via the phone. The care plans were reviewed and updated. Resident C was identified as having a new open area on her heel and treatments to the area were completed by nursing staff. The resident was documented as wearing heel protectors while in bed and when in a recliner. There was no documentation in the note of any new effective intervention to provide complete pressure relief to Resident C's bilateral heels, specifically when she was not in bed or the recliner. A Care Plan, dated 5/23/24, indicated the resident had a Stage II pressure wound to the left heel related to diagnoses of neuropathy and MS. The interventions included, but were not limited to, treatment to wound as ordered, observed wound daily for signs of infection such as redness, pain, purulent drainage, foul odor, edema, warmth to area, dietary supplements as ordered, labs as ordered, turning/repositioning every 2 hours, Registered Dietician to follow for dietary recommendations, encourage resident to elevate bilateral lower extremities one hour twice a day, and heel protectors to feet when in bed/recliner. The care plan did not provide interventions to ensure complete pressure relief to the resident's left heel was initiated and the care plan did not address the pressure injury on the resident's right heel. A Nursing Progress Note, dated 5/23/2024 at 1:40 P.M., indicated a physician's order for a Santyl treatment, (treatment to remove damaged tissue) to the resident's right heel, was discontinued because it was unavailable. A new physician's order for Medihoney (a treatment to provide and support autolytic debridement and provide a moist wound healing environment), Telfa dressing, foam padding and Kerlix wrap after cleaning the wound with wound wash was obtained. A Nursing Progress Note, dated 5/23/2024 at 4:47 P.M., indicated a call was placed to ensure the facility's order for wound culture swabs was being shipped. The supply company indicated the swabs were ready to be sent out and would be expedited. The TAR for May 2024, indicated the Medihoney treatment was started on 5/25/2024. A Nursing Progress Note, dated 5/25/2024 at 4:02 A.M., indicated when the old bandage was removed from the right heel, the scab fell off the right heel and exposed a pink wound bed. There were no other blackened areas remaining on the right heel. The left heel was documented to have a hard black area. The physician was notified of the wound changes. There were no measurements or any further descriptions of the wounds in the nursing progress note for 5/25/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Wound Care Specialist Progress Report, dated 5/29/24, indicated Resident C presented with non-healing pressure ulcerations to the right midline heel and the right posterior heel. The wounds had been present for approximately 30 days with previous treatments of .Wound debridements for the midline heel area and Compression therapy for the posterior heel area. The right midline wound details indicated the wound was a Stage III pressure ulceration, which measured 0.75 cm x 0.8 cm x 0.1 cm. The Wound Evaluation indicated the following: Exudate amount: Moderate, Necrotic tissue: 100%, Wound bed: Full Thickness, Slough and Unavoidable wounds: N/A The right posterior heel wound was a Stage III pressure ulceration measured 2.0 x 1.0 x 0.1 cm. The Wound Evaluation indicated the following: .Exudate amount: moderate, Necrotic tissue: 100% Wound Bed: Full Thickness, Slough. Treatment notes for both wounds indicated to, .Keep are clean and dry. Apply barrier cream such as zinc oxide (Desitin, patient supply added today) There was no mention of the left heel pressure wound. There was also no specific documentation to support the wound care specialist documentation of previous treatments of wound compression therapy. In addition, although the right heel wounds displayed potential signs of infection, moderate exudate described as slough, there was no indication the physician was notified of the status of the wound and potential need for altered treatment. The TARs from April through June 2024 did not include documentation to show staff provided complete pressure relief to the bilateral heels of Resident C with interventions when the resident was both in bed and out of bed. The TAR for May and June 2024, indicated the nursing staff continued to document the application of the skin prep to the bilateral heels, every shift, even after the right heel wounds had opened and the eschar tissue had fallen off. A Nursing Progress Note, dated 6/2/2024 at 4:28 P.M., indicated the resident had refused to wear the pressure relieving boots and insisted on wearing her shoes. Staff had reminded the resident about the amount of pressure the shoes placed on her wound, but the resident still insisted on wearing her shoes. A Wound Care Specialist Progress Report, dated 6/6/24, indicated the resident presented with non-healing pressure ulcerations to the right midline heel and the right posterior heel. The wounds had been present for approximately 30 days with previous treatments of Wound debridements for both areas. The right heel, Stage III midline, pressure wound/ulceration measured 0.73 cm L(length) x 0.8 cm W (width) x 0.1 cm D (depth). The Wound Evaluation indicated Exudate: moderate, Granulation tissue: 80%, Necrotic tissue: 20%, Wound bed: Full Thickness, Slough, The right heel posterior Stage III, pressure ulceration/wound measured 0.3 L x 0.3 W x 0.1 cm D. The Wound Evaluation indicated Exudate: Moderate, Necrotic tissue: 10% and 76-99% epithelialization. There was no mention of the left heel pressure wound and no indication the physician was notified of the signs and symptoms of potential infection of the wound, i.e. slough and moderate exudate. A Nutrition At Risk (NAR) team Progress Note, dated 6/6/24 at 2:04 P.M., indicated the team met to review Resident C for impaired skin and right and left heel pressure areas. The note recommended a MVI (multivitamin) to assist with RDI's (Resident Daily Intake) for wound healing. The rest of the current interventions were to be continued. A Nursing Progress Note, dated 6/6/24 at 4:48 P.M., indicated the resident experienced a significant change in respiratory status and was transferred to an acute care center. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nursing documentation and an MDS assessment, completed due to the resident's discharge from the facility, on 6/6/2024, indicated the resident was discharged with a Stage IV pressure ulcer. According to the NPUAP's (National Pressure Ulcer Advisory Panel) revised pressure ulcer staging guide , copyright 2016 a Stage IV pressure wound reflects a full thickness and loss of dermis with exposed muscle, tendon or bone, During an interview, on 7/2/24 at 1:56 P.M., with RN 4 (previous wound nurse during April/May of 2024), RN 4 indicated the staff had not notified her of resident's eschar, on Resident C's bilateral heels, until 5/20/24 She indicated Resident C had a Stage III pressure ulcer to right heel when she first observed her pressure ulcers and a treatment of Santyl was initiated. She believed the nurses thought since the wound was covered with eschar, it was not a pressure ulcer. RN 4 indicated she did not know why the skin prep treatment was still being documented every shift for Resident C's bilateral heels. RN 4 indicated she was unable to locate any notes for the left heel pressure ulcer and did not know why the left heel was not assessed by the new wound specialist team. The most recent documentation regarding Resident C's left heel wound was completed on 5/21/24. RN 4 was unable to provide any more information regarding the left heel's condition after 5/21/2024. During an interview, on 7/2/24 at 1:56 P.M., with the DON she agreed with RN 4's opinion regarding why the nursing staff had neglected to notify the wound nurse of Resident C's pressure wounds. The DON was unable to provide any more information regarding the left heel's condition after 5/21/2024. During an interview, on 7/3/24 at 10:17 A.M., with the DON, she indicated there were no culture results for Resident C's right heel. In addition, there were no care plans addressing the resident's refusals of the heel protector boots: however, staff had documented some refusals on the TAR. The DON explained some nurses had documented n/a (not applicable) (due to the resident being out of bed) and others had documented R for refusal when the resident was actually out of bed. However, there was no additional documentation on the TAR to support the DON's comments During an interview, on 7/3/24 at 10:17 A.M., with the Assistant Director of Nursing (ADON) and DON, she indicated the new wound specialist's procedures were as follows: assess and observe the resident's wounds weekly on Thursday, the next day (Friday) the wound report would come to the facility, The ADON indicated although the wound reports ad recommendations were being sent to the facility weekly, no one was reading the reports or acting upon any instructions for wound treatments. The DON explained the facility had discovered the issues last week and now those reports were being reviewed timely and their treatments/instructions were being implemented. During an interview,on 7/3/2024 at 11:10 A.M., LPN 3 indicated she had informed the wound nurse, on 4/21/24, of Resident C's heel wounds and she had completed the Skin Evaluation Forms. She indicated the resident was to have a wound culture of the right heel wound, but there were no wound culture swabs available in the facility. LPN 3 indicated she had never received an order to discontinue the lab culture order. She indicated the resident had been declining some but had not displayed any major decline prior to being hospitalized . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	What is Unstageable Pressure Ulcer And How Can You Treat was retrieved , on 7/2/2024, from The Wound Pros Webster at www.thewoundpros.com (the Webster associated with the wound specialist's company). The Webster indicated .An unstageable pressure ulcer is a type of bed sore that occurs due to prolonged pressure on a specific area of the skin, resulting in the lack of blood flow and oxygen to the tissue. It is a full thickness tissue loss where the depth of the wound or bed sore is completely obscured by eschar [a thick, black, or brown scab or crust that forms over the wound] in the wound bed. On 6/28/24 at 1:09 P.M., the DON provided a policy titled, Pressure Injury Prevention and Management, dated 12/2019, revision date 2/26/24 and indicated the policy was the one currently used by the facility. The policy indicated .This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries The facility policy defined an avoidable ulcer as .the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate . This citation relates to Complaint IN00436622. 3.1-40(a)(1) 3.1-40(a)(2)