STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155674	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Charles Health Campus	3150 St Charles St Jasper, IN 47546

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130 Based on interview and record review, the facility failed to ensure services were provided to prevent the development of pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. The facility failed to obtain adequate physician orders or instructions following the removal of a non-removable brace, which resulted in the development of an unstageable pressure ulcer to the left heel (Wound 2). Following an assessment by a wound care clinic that indicated a newly developed unstageable pressure ulcer to the top of the left foot (Wound 3), the facility failed to assess the wound routinely or create a plan of care to address the wound. (According to the National Pressure Injury Advisory Panel [NPIAP], an unstageable pressure ulcer is defined as: wound is obscured by slough or eschar which makes depth and extent of tissue damage unable to be determined.) This deficient practice resulted in the facility failing to prevent and assess developed pressure wounds and failing to update the residents' plan of care for pressure wounds. (Resident D) Findings include: During record review on 2/3/25 at 10:30 A.M., Resident D's diagnoses included, but were not limited to fracture of left tibia, Alzheimer's disease, dementia and anxiety. Resident D's most recent admission Minimum Data Set (MDS) assessment, dated 8/15/24, indicated the resident was admitted to the facility with one unhealed unstageable pressure ulcer (Wound 1), was at risk for developing pressure ulcers, and had severe cognitive impairment. A Braden scale assessment (tool used to predict the risk for developing pressure ulcers), completed 8/12/24, indicated Resident D was at moderate risk for developing pressure ulcers. Resident D's physician orders included, but were not limited to, non-weight bearing to left lower extremity (started 8/12/24), apply foam dressing to deep tissue injury to left great toe (Wound 1) (started 8/1/2/25), observe non-removable dressing to left lower extremity for drainage on dressing and for dislodgement, leave splint in place, do not remove, call orthopedic physician if the brace gets wet (started 8/12/25), cleanse left heel wound (Wound 2), cover with heel foam dressing, cast padding from toes to just below knee, ace wrap from toes to knee, apply heel lift boot (started 8/27/25), cover wound on heel (Wound 2), left great toe (Wound 1), and top of left foot (Wound 3) with bordered foam-wrap, change dressing every other day and assess wounds (started 9/5/25). (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	Resident D's care plan included, but was not limited to, resident has a pressure ulcer to the left great toe (Wound 1) upon admission (initiated 8/14/24) and left heel (Wound 2) (revised 8/29/25). Resident demonstrates non-compliance with plan of care as evidenced by removing dressing and splint (initiated 8/15/25 and revised 9/10/25.) Resident at risk for skin breakdown (initiated and last revised 8/29/25). Resident D's care plan did not include a focus specific to the pressure ulcer to the top of the left foot (Wound 3). Resident D's progress notes included, but were not limited to: 8/12/24 at 12:35 P.M. - Resident arrived at facility with splint/wrap in place to left lower extremity. The family discussed deep tissue injury to the top of the left great toe (Wound 1) that measured 1.5 centimeters (cm) (length) x 1 cm (width) potentially caused by the previous hard splint. 8/13/24 at 2:37 A.M. - Resident had a fracture to the left lower extremity with a non-removable splint in place. 08/15/24 at 2:55 A.M. - Resident continued to remove dressing and splint to left lower extremity. Resident removed dressing two times this shift. 8/16/24 at 3:34 A.M. - Resident continued to be non-compliant with non-weightbearing orders and non-compliant with orders for non-removable dressing and splint to the left lower extremity. The surgical incision site was red and warm to the touch with serosanguineous drainage noted. Orthopedic physician's office notified and awaiting response. Resident complained of pain to the lower left extremity earlier in the shift and treated with pain medication. 8/26/24 at 6:48 P.M. - Resident returned from appointment at orthopedic physician's office with Physician Assistant (PA) 4 with new orders for: 1. Strict non-weight bearing. 2. Daily skin checks. 3. Wound care to the left heel pressure ulcer (Wound 2). 4. Pad heel. 5. Elevate but no direct heel pressure. 08/27/24 at 3:08 P.M. - Staff spoke with resident's family member regarding concern of left heel skin impairment. Also spoke with PA 4 at orthopedic physician's office to update that family was planning to follow up with the wound care clinic. Treatment orders updated and wound management initiated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	08/28/24 at 8:47 A.M. - Resident admitted with deep tissue injury to let great toe (Wound 1). At an orthopedic appointment, the splint was removed with noted pressure to left heel (Wound 2). Resident admitted with non-removable splint to left lower extremity, however the resident removed frequently. Orthopedic physician office updated regarding removal of splint. 09/04/24 at 8:27 A.M. - Upon entering the resident room for assessment and treatment, the left lower extremity dressing and boot had been removed by the resident. 09/11/24 at 8:00 A.M. - Resident continued to remove dressing and boot frequently. Noted two scabs to top of left foot on this date, foam dressing in place. Distal area is 3 cm x 0.5 cm, and proximal area is 2 cm x 0.3 cm. 10/08/24 at 3:50 P.M. -Resident returned from wound care clinic with a football dressing to left foot. This dressing to only be changed weekly per wound care clinic. 10/09/24 at 6:54 A.M. Resident removed football dressing to left foot. Called family to update. Resident D's left heel wound (Wound 2) assessments included but were not limited to the initial wound assessment dated [DATE] at 8:45 A.M., 3.2 cm x 3.6 cm, unable to determine depth, no drainage, no odors, unstageable deep tissue injury. Weekly left heel wound assessments were completed. No weekly assessments were completed for Resident D's left top of foot unstageable pressure ulcer (Wound 3). Resident D's orthopedic physician's office visit notes included, but were not limited to: 8/26/24 - Patient's visit note - Resident D returned for follow up status post Open Reduction Internal Fixation (ORIF) procedure of tibial fracture performed 8/9/24. Family stated resident had some compliance issues and was walking on the postoperative splint. The facility took down the splint and has reportedly replaced it several times. Physical Findings (left foot exam) Resident has a new heel pressure ulcer (Wound 2) that is about the size of a silver dollar. There is concern for potential necrotic tissue. 9/12/24 - Patient's visit note - Resident D returned for follow up status post ORIF procedure of tibial fracture performed 8/9/24. She has a heel ulcer (Wound 2) from a misapplied splint. Resident D's wound clinic visit notes included, but were not limited to: 9/3/24 - Wound visit notes did not include an assessment of Resident D's wounds but did include new treatment order comments of; cover wounds on heel (Wound 2), left great toe (Wound 1), and top of left foot (Wound 3) with bordered foam dressing and remove every other day to assess the site for breakdown and replace the foam boarder. 9/17/24 - Wound care orders included wound location of left heel (Wound 2), left dorsal (upper side or top) foot (Wound 3), and left first toe (Wound 1). 10/8/24 - Wound assessments for the left dorsal (top) foot wound first assessed on 9/3/24 included the wound measurements of 0.5 cm x 0.3 cm x 0.1 cm (depth). (Wound 3) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	10/22/24 - Wound care orders included associated diagnoses an unstageable pressure ulcer of dorsum of left foot (Wound 3) and unstageable pressure ulcer of left heel (Wound 2). During an interview on 4/25/25 at 9:30 A.M., PA 4 indicated having observed Resident D on 8/26/24 during a two week post operative appointment. PA 4 indicated a non-removable splint was applied in the orthopedic physician's office following the Resident's surgical procedure. PA 4 indicated the resident's left foot was wrapped with a padded dressing and a hard splint was applied over the padding. When Resident D arrived for the appointment on 8/26/24, the splint had been applied incorrectly with the padded dressing wrapped around the outside of the hard splint and had resulted in a pressure area to the left heel (Wound 2). PA 4 indicated he was unaware of any notification from the facility regarding Resident D removing the splint and dressing prior to her appointment on 8/26/24. During an interview on 4/25/25 at 10:05 A.M., the Director of Nursing (DON) indicated the wound on top of Resident D's left foot (Wound 3) was assessed on 9/11/24 at the facility as a scabbed area and not a pressure ulcer, therefore the wound was not entered into a wound management program that would have initiated routine wound assessments. During an interview on 4/25/25 at 11:00 A.M., the DON indicated that the orthopedic physician's office did not respond to the notification attempt documented on 8/16/24, and the facility staff replaced the non-removable splint themselves (prior to the development of the unstageable pressure ulcer to Resident D's left heel (Wound 2). The facility did not reassess the area on top of Resident D's left foot (Wound 3) following the diagnosis of an unstageable pressure ulcer to the area during a wound care clinic visit on 10/22/24. No weekly assessments of that wound were documented. During an interview on 4/25/25 at 12:10 P.M., LPN 8 indicated nursing staff should document when a physician's office is notified and if awaiting reply. Nursing staff should continue to contact the physician's office if a reply is not received and should document all attempts of notification. On 4/25/25 at 1:30 P.M., the DON supplied a facility policy titled, Guidelines for Pressure Prevention, dated 12/17/24. The policy included, Care plan interventions shall be implemented based on risk factors identified in the nursing assessment Inspect the skin daily during care of signs of breakdown or changes to the skin . Utilize padding for casts and splints. Monitor skin closely when these devices are present . This citation relates to complaint IN00457254. 3.1-40(a)(2)