STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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. Based on interview and record review, the facility failed to ensure residents did not develop new pressure ulcers and ensure services were provided for treatment of pressure ulcers for 2 of 3 residents reviewed for pressure ulcers (Resident B and Resident C). Resident B developed a Stage III pressure ulcer, and routine wound care orders were not followed. Full wound assessments were not completed routinely, and wound treatments were not documented as completed. Findings include:1. A record review on 5/18/26 at 10:30 A.M., indicated Resident B's diagnoses included, but were not limited to acquired absence of right and left leg below knee, type II diabetes, and peripheral vascular disease (PVD). The most recent quarterly Minimum Data Set (MDS) assessment, dated 2/28/26, indicated the resident had no cognitive impairment, no unhealed pressure ulcers, had bilateral lower extremity impairment, and required substantial/maximal assistance (helper does more than half the effort) with transfers. A Braden scale assessment (tool used to predict the risk for developing pressure ulcers), completed 2/23/26, indicated Resident B was at risk for developing pressure injuries. Physician orders included, but were not limited to, weekly skin assessment (started 6/7/25) and resident see's wound center for treatments and consults (started 4/15/25).Resident B's care plan included, but was not limited to, has potential/impairment to skin integrity due to PVD and diabetes, per wound care stage III pressure ulcer to buttocks (revised 5/18/26). Interventions included, but were not limited to, follow facility protocols for treatment of injury and medications/treatments as ordered (revised 5/13/26).Nurse's progress notes included but were not limited to:5/4/26 at 8:57 P.M. - Resident with reports of worsening low back pain. He reports that pain is tension related and is due to sitting in his chair for long periods of time, and due to his mattress. He states the facility is working on getting him a better mattress to help relieve pressure from his coccyx.Wound center visit notes included:5/4/26 - Pressure ulcer located on the right buttocks has been present for two weeks. According to the National Pressure Injury Advisory Panel (NPIAP), the pressure ulcer is classified as a Stage III. The problem was identified after paralysis or immobility. The ulcer developed in the context of a major change in health status. The patient's mattress provides inadequate off-loading. The patient's wheelchair cushion provides inadequate off-loading. The ulcer occurred in the context of prolonged period of bed rest. Additional factors that contribute to non-healing included diabetes, difficulty implementing off-loading, and lack of adherence to medical recommendations. - Pressure Ulcer to right buttocks onset 4/24/26 - first noted 5/4/26. There is moderate serosanguineous exudate draining from ulcer. The ulcer bed has exposed subcutaneous tissue. This is a full thickness ulcer. The skin around the ulcer is dry/scaly, hyperpigmented, and non-blanchable. There is between 0 - 25% granulation with a confluent pattern of pale quality. There is over 50% nonviable material of slough/fibrin. Measurements - 0.5 centimeters (cm) (length) x 0.2 cm (width) x 0.1 cm (depth). Treatment orders included - cleanse the area with Vashe Wound Solution and apply Calmoseptine to peri-wound skin, daily for one week. Pressure to be offloaded using alternating air mattress. 5/8/26 - Stage III pressure ulcer to right buttock. There is a moderate amount of serosanguineous exudate draining from the ulcer. The ulcer bed has exposed subcutaneous tissue. This is a full thickness ulcer. The skin around the ulcer is dry/scaly, hyperpigmented, and non-blanchable. The ulcer is not malodorous. There are no signs of epithelialization. The ulcer border is well defined. There is between (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	0 and 25% granulation with a confluent pattern of pale quality. There is over 50% nonviable material of slough/fibrin. Measurements were taken of a well-defined single wound on the right buttock. The ulcer measures 0.4 cm x 0.2 cm x 0.1 cm. The wound had a bandage on it. Educated patient to have facility apply cream daily and do not add bandage. Treatment order - cleanse the area with Vashe Wound Solution. Apply Calmoseptine to peri wound skin. This treatment will be done daily for one week. Today's treatment will be performed by the wound care team and other care performed by the patient and the staff. The pressure ulcer was debrided using mechanical debridement. The pressure ulcer is to be offloaded using alternating air mattress.5/11/26 - The pressure ulcer to Right buttock measures 2.0 cm x 0.8 cm x 0.1 cm. The Pressure Ulcer has moderate amount of serosanguineous exudate. The Pressure Ulcer has exposed subcutaneous tissue. The Pressure Ulcer was debrided using mechanical debridement. Patient reports the facility has given several reasons why they feel he cannot have the air mattress that was ordered by this clinic last week. There is a moderate amount of serosanguineous exudate draining from the ulcer. The ulcer bed has exposed subcutaneous tissue. This is a full thickness ulcer. The skin around the ulcer is dry/scaly, hyperpigmented, and non-blanchable. The ulcer is not malodorous. There are no signs of epithelialization. The ulcer border is well defined. There is between 0 and 25% granulation with a confluent pattern of pale quality. There is over 50% nonviable material of slough/fibrin. The plan for the pressure ulcer is to cleanse the area with Vashe Wound Solution. Apply Calmoseptine to peri-wound skin. This treatment will be done daily for 1 week. Today's treatment will be performed by the wound care team and their care performed by the patient and the staff.Facility skin assessments included:5/3/26 - Skin Observation Tool - weekly skin assessment warm, dry, and intact. Left below knee amputation, right below knee amputation wound care at wound care center. 5/16/26 - Skin Observation Tool - weekly skin assessment warm, dry, and intact.No right buttock wound documentation was found on a facility record or wound care center records between 4/24/26 and 5/4/26. Resident B's facility medication administration record/ treatment administration record (MAR/TAR) included no treatment order or treatment documentation for the Stage III pressure ulcer on the right buttock from the wound care center on 5/4/26 through the review date (5/18/26). Observation and interview on 5/18/26 at 1:50 P.M., Resident B was sitting in a motorized wheelchair in his room. A cushion was placed in the wheelchair. The resident's bed did not have an air mattress but a pillow-top mattress per resident. The resident's bilateral below knee amputation stumps were wrapped with a protective covering. Resident B indicated he had a pressure ulcer to his buttocks that was painful. Resident B indicated despite having the bilateral amputation, he can and does transfer himself in his room and had been working with an outside therapy service with a transfer board, though he had not utilized one in the facility. Resident B indicated a concern with an air mattress potentially causing falls from his bed and that he was satisfied with his current mattress. The resident's right buttock wound was treated at the wound care center three times a week and the facility did not provide wound treatment to his buttocks. Interview on 5/19/26 at 1:00 P.M., the Director of Nursing (DON) indicated Resident B's pressure ulcer was found by the wound care clinic. The facility first learned of the wound following the 5/4/26 wound center visit. Unsure why the wound care clinic stated the wound developed on 4/24/26. The facility was unaware of any wound orders to be completed at the facility and had not seen the wound care order from the wound care center. The DON indicated the resident often refused the let nursing staff apply treatments and they had taken the resident's word that the wound care center was going completed all the wound treatments. No wound assessments were completed at the facility due to the resident assessments being completed three times a week at the wound care clinic.2. The record review on 5/19/26 at 10:00 A.M., indicated Resident C's diagnoses included, but were not limited to type II diabetes, hemiplegia affecting right dominant side, heart disease, dementia, and overactive bladderThe most recent quarterly Minimum Data Set (MDS) assessment, dated 4/30/26, indicated the resident had severe cognitive impairment, an unhealed stage II pressure ulcer, and was dependent for mobility and transfers. A Braden scale assessment (tool used to predict the risk for developing pressure ulcers), (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	completed 4/30/26, indicated Resident C was at risk for developing pressure injuries. Physician orders included, but were not limited to, weekly skin assessment (started 6/9/25), Wound care orders for open area on left buttock: cleanse with normal saline, apply Puracol with silver or similar collagen product and cover with dressing. Change dressing daily one time a day (started 5/5/26.)Resident C's care plan included, but was not limited to, at risk for skin impairment due to weakness, impaired mobility, incontinence, and Stage II pressure ulcer to buttocks (revised 5/4/26). Interventions included but were not limited to follow facility protocols for treatment of injury, medications and treatments as ordered (revised 5/13/26). Nurse's progress notes included but were not limited to, 4/28/26 at 2:45 P.M. - Wound is on left buttock. On 4/28/26 at weekly wound observation tool was created but contained no information. The resident's record contained no other weekly wound observation tool assessments.Weekly skin observation tool assessments included:4/28/26 - First assessment - (Left) buttock Stage II pressure ulcer - 2.4 cm x 2.0 cm x 0.2 cm5/4/26 - Left buttock Stage II pressure ulcer - 2 cm x 2 cm x 0.1 cm5/12/26 (Left) buttock Stage II pressure ulcer - 2 cm x 3 cm x 0.1 cm5/18/26 (Left) buttock Stage II pressure ulcer - 3 cm x 3 cm x 0.1 cm - purplish in color Resident C's MAR/TAR for April and May 2026 indicated an order, Wound care for open area on (left) buttock: cleanse area with normal saline, apply Puracol with silver or similar collagen product, and cover with border foam dressing. Change dressing daily one time a day started 4/14/26 and discontinued 5/4/26. The order was documented daily. No documentation from 5/5/26 to the review date 5/19/26 was included that indicated a treatment order for the stage II pressure ulcer had been completed.During an interview on 5/19/26 at 1:00 P.M., the Director of Nursing (DON) indicated Resident C's treatment order for the Stage II pressure ulcer to buttocks was incorrectly entered into the computer system and was not populating for nursing staff to complete or document the wound order. Nursing staff should use the weekly wound observation tool to complete a full wound assessment, but staff were only using the weekly skin observation to document wound measurements. The DON indicated training was being completed for nursing staff on how to enter orders and what wound assessment tools should be used to fully assess resident wounds. On 5/19/26 at 1:35 P.M., the DON supplied a facility policy titled, [Facility Name] Pressure Ulcer Program dated 5/14/26. The policy included, .3. Nursing staff shall perform within Point Click Care, the Skin Observation Tool at least every 7 days for all residents within the facility. If during that observation a new pressure ulcer is found, then the nursing staff shall complete the Weekly Observation Tool sheet found within Point Click Care and make sure to report it immediately . 4. The DON or designee shall complete the ongoing Weekly Observation Tool with all results being reviewed to assure that healing in (sic) in progress. If after two weeks the skin condition is not improving, the physician should be notified for possible change in treatment .This citation relates to intake 3010925. 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)