STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Health Care Center	1 Sisters of Providence St Mary of the Woods, IN 47876

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure pressure ulcers (skin and tissue damage caused by prolonged pressure) were treated timely after admission for 3 of 3 residents reviewed for pressure ulcers (Residents B, C, and D). Findings include:1. Resident B's record was reviewed on 1/15/26 at 11:16 a.m. Census information indicated the resident was admitted to the facility on [DATE]. A pre-admission screening tool, dated 10/30/25, indicated the resident had a wound to the right buttock. An admission Minimum Data Set (MDS) assessment, dated 11/10/25, indicated the resident had an unhealed pressure ulcer. Hospital discharge instructions, signed 11/3/25, indicated, .Wound care-Mepilex [soft foam dressing] on coccyx [tailbone] wound, barrier cream. An admission skin assessment, dated 11/3/25, indicated the resident had a red, scabbed area on the upper mid back. The assessment lacked documentation there was a wound to the buttocks or coccyx. A wound Nurse Practitioner (NP) note, dated 11/5/25, indicated the resident had blanchable erythema (redness that turns white when pressed) with satellite lesions (small, scattered areas) to the sacrum (tailbone). The NP recommended Triad (zinc based cream for wound healing) cream and antifungal powder twice daily and leave open to air for 14 days. A physician's order, dated 11/8/25, indicated cleanse area on buttocks with soap and water, pat dry thoroughly, apply house antifungal powder, keep buttocks clean and dry and prevent skin to skin contact, prevent excessive moisture and apply barrier protection as needed, and leave the area open to air every day and night shift. The order was discontinued on 11/25/25. A physician's order, dated 11/8/25, indicated apply a thick layer of Triad cream and house antifungal powder to buttocks, keep buttocks clean and dry and prevent skin to skin contact, prevent excessive moisture, apply barrier protection as needed, leave open to air twice daily. The order was discontinued on 11/25/25. A Treatment Administration Record (TAR), dated November 2025 lacked documentation a physician's order was obtained for a treatment to the resident's buttocks or coccyx prior to 11/8/25. A skin check note, dated 11/10/25, indicated the resident had moisture associated skin damage to the right buttock that was acquired in house. A physician's order, dated 11/25/25, indicated cleanse area of buttocks with soap and water, pat dry thoroughly, apply layer of Triad (zinc based cream for wound healing) cream and house antifungal powder to buttocks, keep buttocks clean and dry and prevent skin to skin contact, prevent excessive moisture, apply barrier protection as needed, leave open to air twice daily. The order was discontinued on 12/4/25. A wound NP progress note, dated 12/3/25, indicated the facility requested the NP re-evaluate the resident's sacrum. A stage three (full-thickness tissue loss extending into the fatty layer) pressure ulcer was noted to the resident's right inner buttock. The NP recommended a treatment of medical grade honey to the wound. A physician's order, dated 12/5/25, indicated cleanse wound with wound cleanser, pat dry, apply medical grade honey to the base of the wound, secure with bordered gauze, change dressing daily and as needed. The order was discontinued on 12/18/25. A TAR, dated December 2025, lacked documentation a physician's order for a treatment to the resident's right inner (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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(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	buttock pressure ulcer was obtained prior to 12/5/25. 2. Resident C's record was reviewed on 1/15/26 at 3:19 p.m. Census information indicated the resident was admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 1/3/26, indicated the resident was cognitively intact and had an unhealed pressure ulcer. A nursing progress note, dated 12/16/25, indicated the resident had a pressure ulcer on each buttock, and the physician was notified. A nursing progress note, dated 12/17/25, indicated the resident was sent to the emergency room (ER). A nursing progress note, dated 12/27/25, indicated the resident returned to the facility. A skin check note, dated 12/27/25, indicated the resident had a wound to the buttocks but lacked documentation of an assessment of the wound or measurements. A physician's order, dated 12/29/25, indicated cleanse the wounds on bilateral buttocks with saline, pat dry, apply medihoney (treatment to promote wound healing) to wound bed, cover with bordered gauze, and change daily. A Treatment Administration Record (TAR), dated December 2025, lacked documentation a physician's order was obtained for a treatment to the pressure ulcers on the resident's bilateral buttocks prior to 12/29/25. A wound Nurse Practitioner (NP) progress note, dated 12/31/25, indicated the resident had one stage three (full-thickness tissue loss extending into the fatty layer) pressure ulcer to the left buttock and one stage three pressure ulcer to the right buttock. The wound NP recommended a treatment of Triad (zinc based cream for wound healing) paste and Nystatin powder (antifungal) for the wounds. 3. Resident D's record was reviewed on 1/16/26 at 10:27 a.m. Census information indicated the resident was admitted to the facility on [DATE]. A skin check note, dated 1/13/26, indicated the resident was admitted with moisture associated skin damage to the buttocks. A wound Nurse Practitioner (NP) note, dated 1/14/26, indicated the resident had a deep tissue injury to the sacrum (tailbone) that was present upon admission. A physician's order, dated 1/15/26, indicated cleanse wound to sacrum with wound cleanser, pat dry, apply Triad cream (zinc based cream for wound healing) and antifungal powder and leave open to air twice daily and as needed. A Treatment Administration Record (TAR), dated January 2026, lacked documentation a physician's order was obtained for the treatment of the sacral wound prior to 1/15/26. During an interview, on 1/15/26 at 9:37 a.m., the Director of Nursing (DON) indicated she was unable to find any additional documentation treatments were initiated to Resident B, C, or D's wounds at the time of admission. When a resident was admitted with a wound the nurses should have followed the hospital discharge instructions and notify the wound nurse. The facility had a wound NP that made treatment recommendations, but they had to get the orders from the medical director. Treatments should have been ordered at admission or when a wound was found. On 1/16/26 at 9:50 a.m., the DON provided an undated document titled, Skin Condition and Pressure Ulcer Assessment, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.5. If the abnormality noted during the Weekly Skin Assessment is new, the nurse shall notify the attending physician and obtain a treatment order, if indicated. This citation relates to Intake 2689447. 3.1-40(a)(2)