STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155374	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LOOGOOTEE HEALTHCARE & REHABILITATION CENTER	313 POPLAR ST LOOGOOTEE, IN 47553

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 observation, interview, and record review, the facility failed to consistently and accurately assess pressure wounds as to the accurate location and stage; failed to date and time dressings; failed to follow the physician's orders [REDACTED]. (Resident B) Findings include: On 7/22/20 at 9:40 A.M., LPN 2 indicated Resident B was admitted to the facility with excoriated (reddened) areas on the back of her upper thighs. On 7/22/20 at 9:55 A.M., a skin assessment was requested. Resident B was lying on an air mattress. CNA 1 and CNA 2 positioned the resident on her side. A reddened area with 2 small superficial open areas was observed under the left buttock, upper thigh crease area. The right lower buttock upper thigh area had an ABD dressing, undated and untimed, and with old appearing, dried tannish, dark brown drainage. There was no non-adherent dressing. A larger open area was observed with a reddish wound base. CNA 2 reapplied the soiled dressing over the area. The clinical record of Resident B was reviewed on 7/22/20 at 2:15 P.M. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An additional physician's orders [REDACTED]. Cover (with) gauze or ABD pads, rolled gauze. Change as needed. A Care Plan, dated 7/6/20 and updated 7/15/20, indicated, admitted with: Unstageable pressure ulcer Right buttock below crease. Unstageable pressure ulcer left buttock below crease. The Interventions included: 1. Keep areas clean and dry. 2. Treatment per MD orders. 3. Measure/document areas weekly and with change in size Nurse's Notes included the following notations: 7/7/20 at 10:30 A.M.: Admission skin assessment completed .areas noted 1. bilateral buttocks MASD (moisture associated skin damage) excoriation. 2. Stasis ulcer rt. (right) calf 2 cm (centimeters) long x 3 cm wide, 3. Unstageable pressure ulcer right buttock crease (with) yellow slough thin layer 14 cm W (wide) x 9 cm long. 4. Unstageable pressure ulcer left lower buttock crease 7 cm long x 13 cm wide (with) thin layer of yellow slough noted. All areas cleansed et (and) dressed A Wound/Skin Healing Record indicated the following: Description of Stages: Stage 2: Partial-thickness loss of skin .Granulation tissue, slough and eschar are not present .Unstageable Pressure Injury: 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 or eschar .Description of Wound Bed: .Slough - yellow or white tissue that adheres to the wound bed in strings or thick clumps, or is mucinous. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed .Date of Onset: 7-6-20, Original Stage: unstageable, Site/Location: Left side below buttock in crease. 7-7-20, Unstageable, 7 cm L, 13 cm W .Wound Bed Slough .7-14-20: Stage 2, Size 10 cm W, 4 cm L .wound bed Slough . There were no measurements or assessments after 7-14-20. A Wound/Skin Healing Record indicated the following: .Date of Onset: 7-6-20, Original Stage: unstageable, Site/Location: Rt (right) side below buttock in crease. 7-7-20, Unstageable, 9 cm L, 14 cm W, Exudate (drainage) Amount: None .Wound Bed Slough .7-14-20: Unstageable, Size 7 x 3 L .wound bed Slough . There were no measurements or assessments after 7-14-20. A Non-Pressure Skin Condition Report indicated the following: Date First Observed: 7-7-20. Site/Location: Bilateral buttocks scattered excoriation, Moisture-Associated Skin Damage (MASD) .7-14-20 Less scattered areas much improved. There was no documentation after 7-14-20. A Non-Pressure Skin Condition Report indicated the following: Date First Observed: 7-6-20. Site/Location: Rt calf, Venous/Stasis ulcer, 2 x 3 cm .7-14-20, Size 2 x 2 (centimeters), dry. There was no documentation after 7-14-20. A physician's orders [REDACTED]. Leave areas open to air. Nurse's Notes continued: 7/16/20 at 2:00 P.M.: .Open areas to bil (bilateral) thighs open to air, some drainage noted upon return from therapy today 7/18/20 at 2:00 P.M.: .staff to cushion WC (wheelchair) with pillow when she is up due to open areas draining on back of thighs 7/19/20 at 3:00 P.M.: .2 areas on back of legs healing slowly, dressing placed prn for excessive drainage when up. Left OTA (open to air) in bed 7/19/20 at 6:50 P.M.: Res (resident's) bilat (bilateral) leg wounds weeping when she is OOB (out of bed) (and) active (and) in WC so a dressing was applied prn for drainage when up. Left OTA as ordered when in bed. A physician's orders [REDACTED]. Cover areas to Bil legs (with) non-adherent drs (dressing) then cover (with) gauze or ABD pad for wheeping (sic) while not in bed. A Monthly Summary, dated 7/21/20 from 7A-7P, indicated, Skin Conditions: # of Stage 2 pressure ulcers: 2 Resident B's Treatment Administration Record (TAR), dated July 2020, indicated the resident had [MEDICATION NAME] AG applied last on 7/11/20. An entry on the TAR which indicated, Apply non-adherent Dsg to back of bil. legs, cover (with) ABD or gauze for wheeping (sic) while not in bed was initialed as completed 7A-7P on 7/21/20. An entry on the TAR which indicated, Leave Areas open to air on back of bilateral legs while in bed was initialed as completed 7P-7A on 7/21/20. On 7/22/20 at 3:00 P.M., LPN 2 attempted to clarify Resident B's physician orders [REDACTED]. LPN 2 indicated different nurses would call the areas different things. She thought the resident had stasis ulcers on her lower leg, and 2 open areas under each buttock in the creases. LPN 2 indicated she had not been working for a few weeks, but that the last she knew, the dressings were going to be kept off the lower buttocks/upper thighs areas. The stasis ulcer was healed. On 7/22/20 at 3:05 P.M., a reassessment of Resident B's skin was requested. LPN 2 and CNA 3 assisted the resident in positioning. The resident's right lower calf had a scabbed area, with dry, flaky skin surrounding it. The same soiled dressing was observed on the resident's lower right buttock area. LPN 2 indicated she thought something needed to be placed on the pressure ulcer, and she was going to obtain some Zinc or something. LPN 2 indicated the areas actually looked better from when she had seen them previously. On 7/22/20 at 3:30 P.M., RN 2 was interviewed. RN 2 indicated she was the acting Director of Nursing. She indicated she had performed the initial skin assessment, and that Resident B had excoriated areas around her buttocks, and the 2 unstageable areas under both buttocks in the creases. She indicated the resident also had a stasis ulcer on her lower right leg. The resident never had any areas on her ischium that she was aware of. Different nurses performed the weekly skin assessments. On 7/22/20 at 4:00 P.M., RN 2 provided the current facility policy, Skin Management Program, dated 10/2013. The policy included: A resident with a newly identified skin condition will have the appropriate ongoing monitoring form initiated on the basis of the 'type' of skin condition .The plan of care will be developed upon initial identification of a skin condition and reviewed and revised ongoing in regard to wound healing or lack thereof. Revisions of interventions will be communicated to direct caregivers .Interventions will be implemented according to the individual resident's risk factors in an effort to .promote the most effective healing of existing areas This Federal tag relates to Complaint IN 994. 3.1-40(a)(2)
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered as prescribed by the physician, resulting in duplication of [MEDICAL CONDITION] medications, for 1 of 3 residents reviewed for medication use (Resident D). Findings include: The clinical record of Resident D was reviewed on 7/22/20 at 11:30 A.M. [DIAGNOSES REDACTED]. A Social Service Progress Note, dated 3/30/20 and untimed, indicated, Staff reports cont. (continued) issues. (Name of behavior unit) contacted and (name of physician) felt a return to the unit would be appropriate. Res (resident) transported back to (name of behavior unit). A hospital discharge note, dated 4/21/20, indicated, .referred to (name of behavior unit) for being very restless, anxious . Upon discharge, patient is cooperative with care and her sleep has improved .Patient's medication (sic) were adjusted during inpatient stay according to symptoms and behaviors observed The hospital's discharge orders included the following medications: [REDACTED]. The discharge orders did not indicate the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident was to continue the previous [MEDICAL CONDITION] medications of [MEDICATION NAME] 100 mg daily (an anti-depressant), [MEDICATION NAME] 30 mg at bedtime (an anti-depressant), or Quetiapine (also known as [MEDICATION NAME], an anti-psychotic) 50 mg during the day and 100 mg at bedtime. The resident's Medication Administration Record [REDACTED]. The resident also received the newly prescribed medications of Risperdone .5 mg on 4/22 and 4/23, and [MEDICATION NAME] 20 mg on 4/22 and 4/23. A Nurse's Note, dated 4/22/20 and untimed, indicated, Notified MD et (and) Admin (Administrator) et family of med error made upon readmission. A physician's orders [REDACTED]. A Physician's note, dated 4/24/20, indicated, She was recently discharged from (name of behavior unit) .Upon readmission to the facility it was noted that the patient was continued on [MEDICATION NAME] by mistake, we have recently discontinued that. The patient was lethargic (tired) for the past 2 days On 7/22/20 at 3:30 P.M., RN 2, the acting Director of Nursing, indicated it was the facility policy for 2 nurses to check admission and readmission orders [REDACTED]. She indicated she wasn't sure if the resident had even received the medications. On 7/22/20 at 4:15 P.M., RN 2 provided the current facility policy, New Medication Orders, undated. The policy included: 1. Any time a resident is admitting or returning from an outside stay, all medications shall be reviewed, transcribed, and verified by the physician. The initial transcriber shall place 'noted by (initials), date, and time once transferred to the MAR (Medication Administration Record) or TAR (Treatment Administration Record). 2. A second nurse will review the transcribed orders to verify correctness and sign off on MAR indicated [REDACTED]. 3. Nightshift Nurses will complete the nightly chart checks and review any new order for the order being written correctly and that the order was transcribed properly on the MAR indicated [REDACTED]. 3.1-48(a)(1)