STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUBURN VILLAGE	1751 WESLEY ROAD AUBURN, IN 46706

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** Based on interview and record review, the facility failed to assess, track and provide necessary care and treatment to pressure ulcers for 2 of 3 residents reviewed (Resident H and Resident J). The deficient practice resulted in Resident H and Resident J's wounds worsening and/ or becoming infected and requiring treatment with antibiotics. Findings include: 1. On 6/1/20 at 11:35 P.M., Resident H's record was reviewed. [DIAGNOSES REDACTED]. A Nurse Progress note, dated 04/28/20 at 5:45 p.m., indicated the resident was admitted to the facility. She was alert and oriented with long and short term memory intact. Skin assessment indicated she had multiple wounds and would have the wound care physician to follow. An admission MDS (Minimum Data Set) assessment, dated 5/5/20, indicated the resident had a BIMS (Brief Interview Mental Status) score of 15 which signified she had no cognitive impairment. She required extensive assistance from 2 staff for bed mobility and personal hygiene and was frequently incontinent of bowel. She had 1 Stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) and 1 surgical wound. A Care Plan, dated 4/28/20 and updated 4/30/20, indicated the resident was at risk for skin breakdown related to decreased sensory perception, bowel and bladder incontinence, bedfast, required assistance with mobility while in bed/chair, and risk for friction and shear. The goal was the resident would remain free from serious complications related to skin breakdown. Interventions included, but were not limited to, avoid shearing resident's skin during positioning, transferring, and turning; notify MD of changes; report any signs of skin breakdown; and weekly skin assessment. There was no care plan developed to address the resident's pressure ulcers identified upon admission to the facility. A Weekly Treatment (Non Pressure Ulcer) Documentation form, dated 4/29/20 at 8:11 p.m. and completed by the facility wound nurse, indicated Resident H was admitted to the facility with multiple wounds which included, but were not limited to: Wound A- located on the left lateral shin was covered with eschar (Dead or devitalized tissue that was hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) that measured 6.6 cm x 3.2 cm. A Physicians order, dated 4/29/20, was for the left lateral/outer calf to be washed with water and soap, patted dry, and Xeroform and dry dressing applied 2 times per day. A Weekly Treatment (Non Pressure Ulcer) Documentation form, dated 5/6/20 at 11:42 a.m., indicated Wound A remained with an eschar and measured 6.6 cm x 3.2 cm. Wound interventions remained effective, improvement was noted, and staff were to continue the current plan of care. There were no assessments or measurements of Wound A found between 5/6 and 5/18/20. Wound Management Documentation, dated 5/18/20 at 2:30 p.m., indicated Wound A on the left lateral/outer calf measured 7.5 cm x 5 cm. The wound bed was completely covered by black eschar and was draining light [MEDICAL CONDITION] (serum and pus) drainage. The wound healing status was noted to be stable. The resident was to be seen by the facility wound care physician on 5/19/20. An Initial Wound Evaluation and Management Summary by the wound care physician and dated 5/19/20, indicated Wound A was an unstageable pressure wound that measured 7.5 cm x 5 cm. The wound bed was 90% covered with black thick adherent necrotic tissue and 10% slough. The wound was draining light serous drainage. The wound was surgically debrided and new treatment orders given to cleanse the wound with wound wash, pat dry, apply Santyl to the necrotic wound bed, and secure with an island dressing 1 time per day. Wound B-located on Resident H's right lower abdomen, classified as a bruise, was purple in color without any open areas. The area measured 7 cm x 7.8 cm. A physician order, dated 4/29/20, was for the right lower abdomen to be washed with water and soap, patted dry, and Xeroform and dry dressing applied 2 times per day. A Weekly Treatment (Non Pressure Ulcer) Documentation form, dated 5/6/20 at 11:42 a.m., indicated Wound B remained on the resident's right lower abdomen, presented as bruising. The area measured 7 cm x 7.8 cm. There were no assessments or measurements of Wound B found between 5/6 and 5/18/20. Wound Management Documentation, dated 5/18/20 at 2:22 p.m., indicated Wound B, located on the resident's right lower abdomen measured 10 cm x 12 cm. The wound was draining light [MEDICAL CONDITION] drainage. The wound was unstageable and was 100% covered with necrotic tissue. The wound healing status was noted as stable. The resident was to be seen by the facility wound care physician on 5/19/20. An Initial Wound Evaluation and Management Summary by the wound care physician and dated 5/19/20, indicated Wound B was a Stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) pressure ulcer due to shear, under the pannus (dense layer of fatty tissue on the lower abdomen) of an obese patient. The area measured 10 cm x 12 cm and had moderate serous drainage that had a foul odor. The wound bed was 10% covered with thick necrotic tissue, 50% slough, and 40% granulation tissue. The wound was surgically debrided and new treatment orders given to cleanse the wound with wound wash, pat dry, apply Santyl to the necrotic wound bed, sprinkle [MEDICATION NAME] (anti-fungal) to the wound bed to control odor, cover with Alginate dressing and secure with an island dressing. Nurse Practitioner progress notes, dated 4/30, 5/1, 5/6, 5/8, 5/12, 5/16 and 5/18/20 indicated Resident H had been admitted with several wounds which were being monitored and treated by the facility's wound doctor. The NP progress note, dated 5/16/20 at 9:27 a.m. for the 30 day admit regulatory visit, indicated the facility wound care physician would continue to follow and treat for complicated wounds. The note indicated to refer to the wound care physician notes for further details. A review of the notes of the wound care physician indicated he had not begun treatment for [REDACTED]. 2. On 6/1/20 at 1:36 P.M., Resident J's records were reviewed. [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 5/12/20, indicated the resident was in a comatose state. She was dependent on 2 staff for bed mobility, transfers, toileting and personal hygiene. She was always incontinent of bowel and bladder. Resident J was admitted with 3 unstageable pressure ulcers and other open [MEDICAL CONDITION]. Care plans, dated 5/5/20, indicated the resident had pressure wounds to her left gluteal/buttock, right heel and left heel. The goal was that she would have no complications related to skin breakdown. Interventions included, but were not limited to, monitor skin condition per protocol and monitor for signs/symptoms of infection. A Nurse Progress note, dated 5/5/20 at 6:31 p.m., indicated the resident had been admitted to the facility. A head to toe skin assessment was completed by 2 staff nurses and the facility wound nurse which included, but were not limited to the following wounds: -Pressure area to right heel which measured 1.6 cm x 2.6 cm. -Pressure area to left heel which measured 0.8 cm x 0.6 cm. -Shearing to the coccyx which measured 2.4 cm x 2.5 cm x 0.1 cm. -Shearing to the left and right side of anus had an area of excoriation that measured 4 cm x 4 cm x 0.1 cm. The documentation did not include a description of the wound bed, drainage, margins/surrounding skin, or odors. There was no documentation regarding an area to the coccyx. A Skin Integrity Observation form, completed by the facility wound nurse on 5/5/20 at 3:29 p.m., indicated Resident J had wounds which included, but were not limited to: -Left buttocks with an eschar-there were no measurements documented. -Anal: excoriation with hemorrhoids that measured 4 cm x 4 cm. -Right heel that had a thin eschar and measured 1.6 cm x 2.6 cm. The area was callused and blanchable without drainage. -Left heel that had a light brown eschar that measured 0.8 cm x 0.6 cm. The heel was blanchable and heavily callused with no drainage observed. No documentation was available for review regarding the area to the coccyx. A Physician order, dated 5/6/20, was to cleanse the left gluteal/buttock wound with water and soap, pat dry, apply [MEDICATION NAME] 1.3% cream, then normal saline moistened Kerlix with [MEDICATION NAME] covered with a large foam dressing 1 time per day. There were no other treatments ordered for the coccyx, anal, or bilateral heel wounds. A Weekly Treatment (Non Pressure Ulcer) Documentation

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) record, dated 5/11/20 at 11:39 a.m., indicated the following wound assessments and measurements: -Left gluteal/buttock had a sloughing wound bed that measured 6.1 cm x 6.3 cm. -Right heel remained unchanged with an eschar that measured 1.6 cm x 2.6 cm. -Left heel remained unchanged with a light brown eschar that measured 0.8 cm x 0.6 cm. The record indicated current interventions for the wounds were effective and improvement was noted. There was no documentation regarding an area to the coccyx. Nurse Practitioner Progress notes, dated 5/8, 5/11, 5/13, and 5/14 indicated the resident had miscellaneous wounds and the current treatment plan should continue. A Skin Integrity Observation form, dated 5/13/20 at 11:45 p.m., indicated the resident had a necrotic area to her left buttock and left and right heels and excoriation to the anus. The documentation did not include a description of the wound bed, drainage, margins/surrounding skin, or odors. There were no orders to indicate treatments should be completed to the areas on the heels, coccyx, and anus Nurse Progress notes dated 5/13/20 and 5/14/20 indicated the resident's blood sugars had run high which required NP notification and additional insulin doses administered. A Physician order, dated 5/14/20 at unknown time, was for [MEDICATION NAME] be applied to both of the resident's heels 1 time per day. A Nurse Progress note, dated 5/18/20 at 10:02 a.m., indicated staff had been providing care to the resident when the wound on her buttocks was noted to have a foul smell. The NP was notified and orders were given to have the facility wound nurse culture the wound. The resident's coccyx wound had a foul odor which was new. At 12:34 p.m., new orders were given to administer Keflex (antibiotic) after the coccyx wound was cultured, for coccyx wound infection. At 10:24 p.m., Resident J's spouse called the facility and expressed concern that the resident now had an infection to her coccyx wound. Wound Management Documentation, completed by the facility wound nurse and dated 5/19/20 at 7:20 a.m., indicated the following: -Left gluteal/buttock wound measured 8.6 cm x 7.5 cm and was unstageable. The wound had moderate [MEDICAL CONDITION] foul smelling drainage. The wound was covered 100% with necrotic tissue and the skin surrounding the wound was dry, thin, and weepy. -Right heel wound measured 2.2 cm x 2.6 cm and was covered 100% with necrotic tissue. -Left heel wound remained unchanged with a light brown eschar that measured 0.8 cm x 0.6 cm. The resident was to be seen by the facility wound care physician on this date. An Initial Wound Evaluation and Management Summary by the wound care physician and dated 5/19/20, indicated the following: -Left gluteal/buttock wound was an unstageable pressure area that measured 8 cm x 8 cm and had a depth of 7.5 cm. The wound was surgically debrided and treatment orders given to clean the wound with wound wash, pat dry, apply a thin layer of Santyl to the necrotic area and secure with a foam dressing 4 times per week. -Right and left heels were to remain being treated with [MEDICATION NAME] applied to both heels 1 time per day. -Unstageable pressure ulcer wound was noted to the sacrum and measured 7 cm x 5.5 cm. The wound bed had 20% necrotic tissue, 30 % slough, and 50% granulation tissue. The area was surgically debrided and treatment orders given to cleanse the area with wound wash, pat dry, apply Hydrogel to the wound bed and secure with island dressing 4 times per week. There was no documentation found to indicate the facility had identified the unstageable pressure ulcer wound to the resident's sacrum prior to being treated by the wound care physician on 5/19/20. A NP progress note, dated 5/20/20 at 7:57 a.m., indicated it was a follow up visit for the resident's lab results received that showed an elevated white blood count. The resident had a wound culture of the coccyx wound completed and were awaiting the results. The resident continued on Keflex for the wound infection. A Nurse progress note, dated 5/21/20 at 3:14 p.m., indicated the resident's coccyx/buttocks were black in color, necrotic, and had a foul smell. The resident's family were insisting that she be sent to the hospital for evaluation of elevated blood sugars. An order was obtained and the resident transferred to the hospital, where she was improving. On 6/1/20 at 12:24 P.M., the facility wound nurse was interviewed. During the interview, she indicated that due to some changes in facility policies, there was no consistency with documentation of wounds or wound assessments made by staff. She indicated she tried to keep up with the facility's wounds and their assessments and tracking but this did not always occur timely and there were some wound assessments that had been completed but not documented in the resident's record. When questioned, she indicated she did not know what the facility criteria was for getting the facility's wound care physician involved in residents care despite completing rounds with this doctor every Tuesday. She indicated the facility tried to manage minor wounds themselves and would involve the wound care physician if they weren't able to manage them. She indicated she had not yet received formal training on wound care and was not wound care certified. On 6/3/20 at 1:05 P.M., the DON (Director of Nursing) was interviewed. During the interview, she indicated she was not aware of the criteria set for the wound care physician to be involved in resident's care but she would try to find out. She indicated staff were expected to follow the facility's pressure ulcer policy and procedures and were all re-educated on these policies on 5/27/20 after discovery that wounds were not being assessed, monitored, and documented according to their policies and procedures. The DON indicated the facility wound nurse was, at this time, scheduled for 4 days per week to manage wounds and round with the wound care physician. On 6/3/20 at 2:00 P.M., the DON provided an addendum to the facility's wound care policy which she had just received and indicated the following: Residents with Stage 2 pressure ulcers will be referred to the wound care physician for follow up. The DON indicated residents who had a Stage 2 pressure ulcer or higher would be referred and seen by the facilities wound care physician. On 6/3/20 at 12:36 P.M., the DON provided a current copy of the facility policy titled Pressure Ulcer Prevention Protocol. The policy indicated the following: Residents will be assessed to determine their risk factor(s) for pressure ulcer development .Residents who receive treatment for [REDACTED].the plan of care will include the presence of the pressure ulcer and include the individual description of the treatment plan .the physician will be notified when the assessment indicates a lack of progress in healing .Wound Assessment Policy and Procedure: It is the policy of this facility to do a systemic, ongoing wound assessment on all wounds .A complete wound assessment will be done weekly by a licensed nurse for all wounds, ulcers, and impairments in skin integrity .wound assessments will be documented in the Weekly Pressure Ulcer Documentation Observation .the wound assessment will contain the following information: wound classification, wound location, pressure ulcer staging or description of the extent of tissue damage, description of the wound bed, drainage, margins/surrounding skin, and odor, wound measurements, and wound related pain This Federal tag relates to Complaint IN 943. 3.1-40(a)(2)