STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155325	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW VIEW HEALTH AND REHABILITATION	**900 ANSON ST SALEM, IN 47167**

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 ensure appropriate interventions were in place for a resident (Resident D) who was at risk for developing pressure ulcers, which resulted in the development of an in house unstageable pressure ulcer to the left heel and one stage three pressure ulcer to the sacrum for 1 of 3 residents reviewed for pressure ulcers. Findings include: The clinical record for Resident D was reviewed on 8/31/20 at 11:10 a.m. The resident's [DIAGNOSES REDACTED]. The 5 day admission MDS (Minimum Data Set) assessment, dated 5/28/20, indicated the resident required two physical staff assistance with bed mobility. The significant change MDS assessment, dates 6/11/20, indicated the resident had no rejection of care. The admission observation, dated 5/22/20, indicated there were no alterations in the resident's skin. The Braden Scale for Predicting Pressure Sore Risk assessment, dated 5/22/20, indicated the resident was at risk for pressure ulcers due to occasionally moist skin, severely limited ability to walk, and required moderate to maximum assistance with moving. The care plan, dated 5/25/20, indicated the resident was at risk for skin break down due to occasionally moist skin, ability to walk severely limited and slightly limited ability to change position independently. Interventions included to assess skin weekly, encourage the resident to turn and reposition at least every 2 hours, and to provide assistance as needed. The weekly summary, dated 6/2/20 at 2:09 a.m., indicated there were no alterations in the resident's skin. The wound management detail report, dated 6/2/20 at 11:51 a.m., indicated the resident had a stage 3 pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue) to the sacrum which measured 6 cm (centimeters) in length, 4.5 cm in width, with a depth of 1 cm. The wound management detail report, dated 6/4/20 at 2:29 p.m., indicated the resident had an unstageable deep tissue injury (persistent non-blanchable deep red, purple or maroon areas of intact skin caused by damage to the underlying soft tissue) to the left heel which measured 8 cm in length with a width of 7 cm. The wound management detail report, dated 6/12/20 at 11:56 a.m., indicated the resident had a stage 3 PU to the sacrum which measured 10 cm in length, 12 cm in width, with a depth of 0.3 cm. The resident's left heal had an unstageable deep tissue injury which measured 8 cm in length and 7 cm in width with no depth. The wound management detail report, dated 6/18/20 at 2:07 p.m., indicated the resident had an unstagable PU to the sacrum which measured 10 cm in length, 12 cm in width, with no depth. The resident's left heal had an unstageable deep tissue injury which measured 8 cm in length and 7 cm in width with no depth. The wound healing was declining. The resident was discharge from the facility on 6/23/20 to an acute hospital. During an interview on 8/31/20 at 12:52 p.m., the Director of Nursing indicated the resident acquired the pressure ulcers because of non-compliance with turning/repositioning and the resident just wanted to lay in bed. The clinical record lacked documentation of staff turning and repositioning, floating heels, and a non-compliance plan of care prior to the resident acquiring the pressure ulcers. On 8/31/20 at 2:28 p.m., the Administrator provided a current copy of the document titled Skin Management Program dated July 2020. It included, but was not limited to, Policy .It is the policy .to ensure that each resident receives care, consistent with professional standards, to prevent pressure ulcers and does not develop pressure ulcers This Federal tag relates to Complaint IN 200 3.1-40(a)(1)

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