STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure 3 of 3 residents reviewed for personal hygiene received showers twice weekly and prompt personal care to prevent MASD (moisture associated skin damage). (Resident C , Resident F, Resident G) Findings include: 1. Review of Resident C's clinical record on 3/4/20 at 10:55 a.m., the Quarterly MDS (Minimum Data Set), dated 2/15/20, indicated Resident C was cognitively intact. Resident C's [DIAGNOSES REDACTED]. Resident C was extensive assistance x 1 for bed mobility, extensive assist x 2 transfers, extensive assist x 1 dressing, limited assist x 1 toileting, and totally dependent for bathing. Resident C's care plans indicated the following: 2/3/20, revised 2/23/20- Resident has ADL (activities of daily living) self care deficit and is at risk for complication related to weakness, limitations in mobility, pain with movement, non-ambulatory. Interventions included, but were not limited to, oral care twice daily, showers scheduled 2 (two) times a week and shampoo at least weekly. Staff to provide assistance as needed with mobility tasks. A review of Resident C's showers for January 16- February 15, 2020 indicated the following: 1/16 partial bed bath 1/18 partial bed bath 1/19 partial bed bath 1/20 complete bed bath 1/21 partial bed bath 1/27 partial bed bath 1/28 complete bed bath 2/10 partial bed bath 2/11 complete bed bath 2/13 partial bed bath 2/15 other bath No other dates were indicated in the clinical record. Resident C did not receive a shower in 30 days. During an interview on 3/5/20 8:00 a.m. with the DON (Director of Nursing), she indicated Resident C was non-compliant with care and treatment. He regularly refused showers, medications, and vital signs. The DON was unable to locate and provide shower refusals in the resident's clinical record. The DON indicated Resident C preferred bed baths, but it was not documented or care planned. 2. During an observation on 3/3/20 at 7:40 p.m., Resident F was observed lying on his left side in bed, sleeping. During an observation on 3/4/20 at 1:33 p.m., with LPN 1, Resident F had a new skin area noted on the bilateral buttocks. The skin was red, diluted, with multiple scattered open areas. LPN 1 indicated it was MASD (moisture associated skin disorder) related to his loose stools. During an interview with Resident F on 3/5/20 at 9:42 a.m., he indicated the area on his buttocks was new since having loose stools. Indicated staff has to clean him up as he is unable to do so on his own, and sometimes they are busy and cannot get to him right away. A review of Resident F's clinical record on 3/4/20 at 8:59 a.m., the Quarterly MDS, dated [DATE], indicated Resident F was cognitively intact. Resident F's medical [DIAGNOSES REDACTED]. Resident F required extensive assistance x 2 bed mobility, extensive assist x 1 dressing, extensive assistance x 1 toileting, extensive assistance x 1 hygiene, and total dependence for bathing. The care plans included, but were not limited to, 12/11/19 revised 2/23/20- Resident has an ADL self care deficit and is at risk for complication related to weakness, shortness of breath with exertion, generalized pain/discomfort. Receiving hospice services for [DIAGNOSES REDACTED]. as needed with mobility tasks. 12/11/19 revised 2/3/20- Resident at risk for pressure injury related to altered mobility, incontinence, nutritional status. Interventions included, but were not limited to, assist as needed to reposition, complete Braden scale as indicated, weekly skin review, discuss any noncompliance issues with resident/family, educate resident/responsible party about pressure injury etiology, risk factors, treatment, prevention, encourage use of side rails and or trapeze to turn in bed, notify nurse of any new areas immediately, provide diet as ordered, observe labs as ordered, provide incontinence care after episodes, provide pressure relieving device mattress chair cushion. Use lifting device, draw sheet to reduce friction and shearing. Resident F's admission skin assessment dated [DATE] indicated, petechiae chest, back, no alterations in skin. Resident F's admission Braden Skin, dated 11/29/19 indicated a score of 18, at risk for pressure ulcers. During an interview with the DON on 3/5/20 at 12:00 p.m., she indicated Resident F's new MASD area was due to loose stools. The loose stools were due to Resident F requesting and drinking multiple Boost (supplemental drink). Staff and the resident were educated on reducing the amount of Boost to decrease the loose stools. During an interview with the Regional Nurse Consultant on 3/5/20 at 9:20 a.m., he indicated Resident F had been having loose stools due to drinking multiple Boost (supplement drink). Resident F was a thin man and staff gave it to him whenever he asked for it. He was educated. 3. During an observation on 3/3/20 at 7:35 p.m., Resident G was observed lying in his bed on his back, television on. During an observation on 3/4/20 at 2:34 p.m. with LPN 1, Resident G's periarea was macerated. LPN 1 indicated it was MASD. During an interview with Resident G on 3/5/20 at 11:05 a.m., he indicated his periarea maceration was due to a leaking catheter. Indicated he was not in pain/discomfort. Resident G denied not receiving showers, but did indicate he occasionally had to wait for assistance when he used his call light, sometimes up to a half hour. Review of Resident G's clinical record on 3/4/20 at 8:24 a.m., the Admission MDS, dated [DATE], indicated Resident G was cognitively intact. Resident G's [DIAGNOSES REDACTED]. Resident G required extensive assistance x 2 with bed mobility, total dependence for transfers, extensive assistance with eating x 1, total dependence for toileting, hygiene, and bathing. Resident G's care plans included, but were not limited to, 2/3/20 revised 2/9/20- Resident has an ADL self care deficit and is at risk for complication related to [MEDICAL CONDITION]. Resident is non-ambulatory and dependent on staff for transfers and positioning. Physical dependence on staff for ADL care. 2/3/20- Bed mobility extensive assist x 2, transfers total assist x 2, eating extensive assist x 1, toileting total assist x 2. Interventions included, but were not limited to, oral twice daily, provide meal service in location of preference, provide assistance as needed with meal intake. Report changes to nurse, shower twice weekly and shampoo at least weekly, staff to provide assistance with mobility tasks. Staff to complete transfers with assist x 2 and mechanical lift. Uses motorized wheelchair when out of bed, staff to provide only assistance to meet his needs, assist of 2 transfers, assist x 1 bathing, dressing. The Admission skin assessment, dated 1/15/20 indicated a pinpoint open area on the right upper leg. The Admission Braden Scale, dated 1/15/20 indicated a score of 16 points, at risk for pressure ulcers. During an interview with the DON on 3/5/20 at 8:08 a.m., she indicated the MASD on his periarea was acquired in house and he was not admitted with it. The facility lacked a specific written policy related to ADLs and incontinence care. This Federal tag relates to Complaints IN 905 and IN 424. 3.1-38(a)(3)
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, record review, and interview, the facility failed to ensure residents were free from the development of pressure ulcers for 2 of 3 residents reviewed for wounds. Resident F and Resident G developed pressure ulcers after admission. (Resident F, Resident G) Findings include: 1. During an observation on 3/3/20 at 7:40 p.m., Resident F was observed lying on his left side in bed, sleeping. During an observation on 3/4/20 at 1:33 p.m., with LPN 1, Resident F's deep tissue injury of the right hip was resolved. Resident F's left outer sacrum was covered in slough. LPN 1 indicated it was unstageable and improving. LPN 1's measurements were 0.7 cm (centimeters) x 1 cm (centimeter) x unknown depth with scant, serous drainage. Review of Resident F's clinical record on 3/4/20 at 8:59 a.m., the Quarterly MDS, dated [DATE], indicated Resident F was cognitively intact. Resident F's medical [DIAGNOSES REDACTED]. Resident F required extensive

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

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	155670	A. BUILDING _____ B. WING _____	**03/05/2020**

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SIGNATURE HEALTHCARE OF NEWBURGH	**5233 ROSEBUD LANE NEWBURGH, IN 47630**

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assistance x 2 bed mobility, extensive assist x 1 dressing, extensive assistance x 1 toileting, extensive assistance x 1 hygiene, and total dependence for bathing. The MDS indicated Resident F was at risk for pressure ulcers, but had no pressure or venous ulcers upon admission. The care plans included, but were not limited to, 2/9/20 revised 2/14/20- Resident has a UDT (unstageable deep tissue) ulcer to left outer sacrum related to decreased mobility, incontinence of bowel and decreased tissue perfusion due to [MEDICAL CONDITION], [MED]gen dependence, and hypertension. Measurements 1 x 1 x unknown. 2/1[DATE]6- deep tissue to right hip that is dark red in color and does not blanche. Measurements 9 x 7 cm. Interventions included, but were not limited to, assess and record condition of skin surrounding the pressure ulcer, assess the PI (pressure injury) for location, stage, size, avoid friction and shearing forces during transfer and position changes, conduct a systematic skin inspection weekly on assigned date, encourage to turn and reposition every 2 hours and as needed, keep clean and dry as possible. Minimize skin exposure to moisture. Provide incontinence care after each episode, dietitian to follow, supplements med pass 60 cc twice daily, fortified oatmeal with breakfast, gravy with meats, vanilla and chocolate ice cream with lunch and dinner. 12/11/19 revised 2/23/20- Resident has an ADL self care deficit and is at risk for complication related to weakness, shortness of breath with exertion, generalized pain/discomfort. Receiving hospice services for [DIAGNOSES REDACTED]. as needed with mobility tasks. 12/11/19 revised 2/3/20- Resident at risk for pressure injury related to altered mobility, incontinence, nutritional status. Interventions included, but were not limited to, assist as needed to reposition, complete Braden scale as indicted, weekly skin review, discuss any noncompliance issues with resident/family, educate resident/responsible party about pressure injury etiology, risk factors, treatment, prevention, encourage use of side rails and or trapeze to turn in bed, notify nurse of any new areas immediately, provide diet as ordered, observe labs as ordered, provide incontinence care after episodes, provide pressure relieving device mattress chair cushion. Use lifting device, draw sheet to reduce friction and shearing. Resident F's admission skin assessment dated [DATE] indicated, petechiae chest, back, no alterations in skin Resident F's admission Braden Skin, dated 11/29/19 indicated a score of 18, at risk for pressure ulcers. Weekly skin assessments indicated: 12/6/19 weekly skin assessment- no areas noted. 1/31/20 weekly skin assessment- no areas noted. 2/9/20 shearing to buttocks, facility acquired, physician notified. Resident informed of skin condition and orders received. 1.3 x 3.5, no exudate, wound bed-reddish brown, crusting. Surrounding skin reddened. 3 (three) linear areas that are reddish brown in color and dry. Blanchable redness around areas. No drainage. Treatment initiated. 2/15/20 Medical Nutrition review for wounds Type: pressure ulcer No significant weight change. Regular diet, chocolate/vanilla ice cream with lunch and supper, gravy with all meats. Unstageable wound to right outer hip, unstageable deep tissue injury to sacrum per wound report. Wound management indicated: 2/9/20 Pressure ulcer- Sacrum left outer sacrum Not present upon admission. 2/19/20 1.1 cm x 1.3 cm 2/28/20 1 cm x 1 cm Orders: 2/14/20 Hospice to evaluate and admit if appropriate. 12/2/19 Fortified oatmeal with breakfast. Gravy with meats. Ice cream with lunch and supper. 12/18/19 Head to toe skin checks weekly, once a day on Friday. 12/1/19 Pressure relieving mattress 2/14/20 Skin prep areas to right hip and left outer sacrum and allow to dry. Cover with Dermafilm thin every 3 days and as needed. Deep tissue right hip 12/1/19 Pressure redistribution cushion to wheelchair 2/9/20 pressure ulcer monitoring every shift right buttock and left outer sacrum Progress notes indicated: 2/9/20 at 9:39 p.m.- IDT Review: Resident noted to have DTI to right buttock that measures 0.5 cm x 0.2 cm. Area dark purple in color and does not blanche. UDT ulcer to left outer sacrum that measures 1 x 1 x unknown. Thin yellowish brown crusting to area. Blanchable redness around area. No drainage noted. Physician updated of skin concerns and new treatment orders received. Resident informed of new orders and voiced understanding. Care plan initiated and CNA assignment sheet reviewed and updated. Educated resident on the importance of turning and repositioning in bed to relieve pressure to areas. Also educated on the importance of adequate nutrition to promote and aid in wound healing. He voiced understanding. Continued [DIAGNOSES REDACTED]. Currently receives fortified oatmeal with breakfast, gravy with meats, ice cream with lunch, dinner. 60 cc med pass twice daily. During an interview with the DON on 3/5/20 at 12:05 p.m., she indicated Resident F did obtain the pressure ulcers in house. The hip has healed, but he is still receiving treatment on the sacrum. He was previously on hospice and is now back on it. 2. During an observation on 3/3/20 at 7:35 p.m., Resident G was observed lying in his bed on his back, television on. During an observation with LPN 1 on 3/4/20 at 2:34 p.m., Resident G's wound had granulation tissue, edges dry, intact, moderate red bleeding. LPN 1 indicated it was a Stage III (full-thickness skin loss potentially extending into the subcutaneous tissue layer)pressure ulcer. Review of Resident G's clinical record on 3/4/20 at 8:24 a.m., the Admission MDS, dated [DATE], indicated Resident G was cognitively intact. Resident G's [DIAGNOSES REDACTED]. Resident G required extensive assistance x 2 with bed mobility, total dependence for transfers, extensive assistance with eating x 1, total dependence for toileting, hygiene, and bathing. The MDS indicated Resident G was at risk for pressure ulcers. Resident G was not admitted with pressure or venous ulcers. Resident G's care plans included, but were not limited to, 3/2/20 revised 3/3/20- Resident has disruption of skin surface related to pressure. Pressure ulcer right buttock Interventions included, but were not limited to, complete Braden scale, weekly skin review, inspect skin during bathing or daily care, observe for signs/symptoms of infection or delayed healing and report to physician, provide incontinence care as needed, refer to dietitian as indicated, report changes in skin status to physician, wound care as ordered, observe effectiveness of response to treatment and change as indicated to promote wound healing. 2/3/20 revised 2/9/20- Resident has an ADL self care deficit and is at risk for complication related to [MEDICAL CONDITION]. Resident is non-ambulatory and dependent on staff for transfers and positioning. Physical dependence on staff for ADL care. 2/3/20- Bed mobility extensive assist x 2, transfers total assist x 2, eating extensive assist x 1, toileting total assist x 2. Interventions included, but were not limited to, oral twice daily, provide meal service in location of preference, provide assistance as needed with meal intake. Report changes to nurse, shower twice weekly and shampoo at least weekly, staff to provide assistance with mobility tasks. Staff to complete transfers with assist x 2 and mechanical lift. Uses motorized wheelchair when out of bed, staff to provide only assistance to meet his needs, assist of 2 transfers, assist x 1 bathing, dressing. The Admission skin assessment, dated 1/15/20 indicated a pinpoint open area on the right upper leg. The Admission Braden Scale, dated 1/15/20 indicated a score of 16 points, at risk for pressure ulcers. Weekly skin assessments indicated: 1/16/20 pinpoint open area to RU (right upper) leg area [DATE] pinpoint open area to RU leg area 1/18/20 pinpoint open area to RU leg area 1/19/20 pinpoint area to RU leg area 1/22/20 Braden scale- 13 points, moderate risk for pressure ulcers 2/7/20 coccyx, right posterior thigh, MASD 2/14/20 weekly skin assessment- peri/genital area, new area, redness. When resident foreskin pulled back for pericare, it was found that res penis is very red. Area cleaned with soap/water. 2/23/20 right buttocks area- 3 open, red areas Wound management indicated: [DATE] coccyx right inferior buttock not present upon admission. 3 cm x 2 cm [DATE] coccyx right superior buttock 3.8 cm x 3.5 cm, not present on admission [DATE] coccyx right lateral buttock 3.5 cm x 2 cm, not present on admission 3/4/20 right posterior inferior thigh 3 cm x 1.3 cm x 0.1 depth, light exudate, Stage III (full-thickness skin loss potentially extending into the subcutaneous tissue layer), improving. Note: Wound initially noted on [DATE] and location entered was invalid. right posterior superior thigh- 2.7 cm x 1.3 cm, moderate exudate, Stage III, improving. Note: Wound initially noted on [DATE] and location entered was invalid. During an interview with the DON on 3/5/20 at 8:00 a.m., she indicated the wound nurse was out last week and she did the measurements on [DATE]. She incorrectly noted the locations. Indicated the resident was admitted with the pressure ulcer, but agreed the admission assessment, MDS, and clinical record lacked documentation the resident was admitted with these wounds. Orders: 3/2/20 Cleanse right buttock with normal saline. Pat dry. Cover open areas with derafoam and cover with bordered gauze. Change every 3 days. 1/15/20 Head to toe skin check weekly, complete non pressure obs (observation) or wound management. form if appropriate. Once a day on Thursday. Progress notes indicated: 3/2/20 at 3:12 p.m.- Open areas noted to right buttock. Physician notified. New order to cleanse with NS (normal saline), apply dermafoam and border gauze. Change every 3 days. During an interview with LPN 1 on 3/4/20 at 2:34 p.m., she indicated she was the wound care nurse and had been treating the areas on Resident G. Resident G acquired his pressure wounds in the facility. During a review of the current policy, Pressure Ulcer/Injury-Daily Monitoring, revised 1/8/20, provided by the Regional Nurse Consultant on 3/5/20 at 2:20 p.m., it indicated, Daily evaluation and documentation of the resident's pressure ulcer/injury sites is the standard of care .All residents with a pressure ulcer/injury will have areas evaluated and documented daily in the electronic medical record by the licensed nurse .The licensed nurse will follow the procedure for Skin Integrity template . During an interview with the Regional Nurse Consultant on 3/5/20 at 2:20 p.m., he indicated the facility followed the RAI Manual for MDS evaluations. The facility lacked a specific written policy related to pressure ulcer assessments. This Federal tag relates to Complaints IN 905 and IN 424. 3.1-40(a)(1)