STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLER'S MERRY MANOR	**2901 W 37TH AVE HOBART, IN 46342**

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 observation, record review, and interview, the facility failed to provide treatment and services related to the development of a pressure ulcer to the right heel with no assessment or treatment orders in place, resulting in an unstageable wound for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: Observation on 7/14/20 at 1:15 p.m., Resident F was observed in bed lying on her back. At that time, QMA 1 was asked to turn the resident over onto to her side to observe the pressure ulcer on the coccyx. When the QMA rolled the resident onto her left side, an area to the right heel was observed. The area was black, scabbed, and with bloody drainage. At that time, there was no bandage covering the right heel and there was also dried blood on the bed sheet from the sore. The resident had a bandage in between the crack of her buttocks, however, it was not covering the pressure sore over the coccyx. The bandage was bloody and soiled. At that time, heel boots were observed on the floor by the night stand and not on her feet. Interview with CNA 1 at that time indicated she and another CNA had just repositioned the resident and the bandage on the coccyx could have moved. Interview with LPN 1 on 7/14/20 at 1:30 p.m., indicated she was the nurse on duty taking care of Resident F. No staff had told her the resident had a new open area on the right heel. Interview with the Wound Nurse on 7/14/20 at 1:35 p.m., indicated she had completed a skin assessment on the resident last week on 7/8/20. She had changed the treatment for [REDACTED]. At that time, the Wound Nurse was made aware of the new area on the resident's right heel. She indicated it was not there last week on 7/8/20 when she had changed the treatment for [REDACTED]. She indicated on Saturday, 7/11/20, there was a tiny square bandage noted on the right heel. The resident did not get out of bed for showers, therefore she preferred full bed baths on her shower days. She indicated there was no information on her CNA assignment sheet regarding heel boots for the resident. Observation on 7/14/20 at 1:45 p.m., the Wound Nurse preformed a skin assessment of the resident's right heel and was going to change the bandage on the coccyx. CNA 1 turned the resident onto her left side and the wound to the right heel was observed. The Wound Nurse indicated it was an unstageable (Full thickness tissue loss in which actual depth of the ulcer was completely obscured by slough and/or eschar (necrotic) tissue) pressure ulcer. The ulcer measured 2.5 centimeters (cm) by 5.5 cm. with a moderate amount of bloody drainage noted. The Wound Nurse indicated the right heel had a large amount of black necrotic tissue covering it. She cleansed the ulcer with normal saline and placed a calcium alginate bandage on top of the wound and covered it with a foam dressing. The bandage on the coccyx was not fully covering the pressure ulcer, had no date on it to indicate when it was last changed and was removed by the Wound Nurse. The pressure ulcer was clean and had some bloody drainage noted. The record for Resident F was reviewed on 7/14/20 at 12:32 p.m. [DIAGNOSES REDACTED]. The resident was admitted to the hospital on [DATE] and did not return to the facility until 5/13/20. An Admission Minimum Data Set (MDS) assessment, dated 5/20/20, indicated the resident was alert and oriented with mild cognition deficits. She needed extensive assist with 2 person physical assist with bed mobility and was totally dependent with 2 person physical assist for transfers. She was readmitted with a Stage 2 and a Deep Tissue Injury (DTI) pressure ulcer. The Care Plan, dated 5/13/20, indicated the resident had developed a pressure injury to the coccyx and left buttock. The approaches were to float or bridge heels when in bed and the nurse was to measure/assess weekly and notify family and Physician as needed. There was no Care Plan for the right heel pressure ulcer. The last weekly skin assessment, dated 7/7/20, indicated there was no documentation regarding a pressure ulcer to the right heel. The last documented Nurses' Note, dated 7/10/20 at 4:54 p.m., indicated no documentation regarding the pressure ulcer to the right heel. There was no documentation indicating the Physician was notified of the new pressure ulcer to the right heel. physician's orders [REDACTED]. Change 3 times a week and as needed. physician's orders [REDACTED]. The Treatment Administration Record (TAR) for July 2020, indicated the treatment for [REDACTED]. The as needed treatment was not signed out at all during that time frame. Interview with the Wound Nurse on 7/14/20 at 2:30 p.m., indicated the wound to the right heel was not there last week when she last assessed it on 7/8/20. She indicated there was a wound protocol for the nurses to follow when a new wound was found. A new skin authorization form was to be completed and that information goes to the dashboard. When she comes to work the next day, depending on how many days she had been off, she would look back that far on the dashboard to see if there was anything new she needed to observe and assess. There was no documentation or information on the dashboard regarding the pressure ulcer to the right heel. She indicated she was the only person allowed to Stage pressure ulcers, however, she had made a template for the nurses to follow to obtain a treatment, depending on where and what the wound looked like. She had been off and out of the facility 7/10-7/13/20. The current 8/14/2014 Skin Management Program policy, provided by the Wound Nurse on 7/14/20 at 3:10 p.m., indicated Communication will occur with the resident and Physician when there is a change in condition and or a change in treatment plan. Nursing staff will communicate changes via 24 hour condition report and written or electronic nurse aide assignments. This Federal tag relates to Complaints IN 335 and IN 758. 3.1-40(a)(1) 3.1-40(a)(3)

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