STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUTHERAN LIFE VILLAGES	**6701 S ANTHONY BLVD FORT WAYNE, IN 46816**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate notifications for change in condition for 1 of 3 residents reviewed. (Resident B) Findings include: 1. The clinical record of Resident B was reviewed on 7/7/20 at 11:50 a.m. [DIAGNOSES REDACTED]. The admission MDS (Minimum Data Set) Assessment, dated 5/27/20, indicated a BIMS (Brief Interview for Mental Status) Score of 13, which indicated resident was cognitively intact. The assessment also indicated the resident had 1 unstageable pressure ulcer due to eschar (dark dead tissue) or slough which was present on admission. Review of nurses notes indicated the following: On 5/20/20 6:52 p.m., Resident B was admitted to the facility after an acute hospital admission and a rehabilitation hospital admission. The nurse's note indicated [MEDICAL CONDITION] was present in left lower extremity with recent [DIAGNOSES REDACTED]. The resident also had multiple bruises and lacerations from falls. The nurse's note on 5/21/20 at 6:26 a.m., indicated Resident B was forgetful but pleasant. The resident remained on an antibiotic for [MEDICAL CONDITION] of left foot and the left great toe remains swollen, red and slightly tender to touch and denied pain. A new physician's orders [REDACTED]. A nurse's note on 5/22/20 at 04:38 a.m., indicated Resident B was forgetful but pleasant. The resident remained on an antibiotic for [MEDICAL CONDITION] of the left food. The left great toe wound remained swollen, red and slightly tender to touch, but the resident denied pain when asked. Resident B's bilateral lower extremities had 2+ [MEDICAL CONDITION]. A nurse's note on 5/23/20 at 02:06 a.m., indicated Resident B was alert and oriented to self and surroundings, forgetful but pleasant. The resident remained on an antibiotic for [MEDICAL CONDITION] of left foot and left great toe. The left great toe wound was slightly swollen, red and slightly tender to touch.The resident had 2+ pilling [MEDICAL CONDITION] to bilateral lower extremities. The resident denied any pain when asked. A nurse's note on 5/23/20 at 3:03 p.m., indicated Resident B's left foot was noted to have eschar surrounded by slough, erhythmic (superficial reddening of skin) and slight swelling extended down to left foot. The area on the left foot was warm and resident remained on an antibiotic. Documentation was lacking for notification to the Physician, the Nurse Practitioner, nor the POA for the change in resident's wound. A nurse's note on 5/23/20 at 11:36 p.m., indicated Resident B remained on an antibiotic for the infection of the left great toe. The dressing to the wound was clean, dry and intact with slight swelling with mild redness noted around the dressing. Documentation was lacking for notification of the wound status to the POA. A nurse's note on 5/24/20 at 3:16 p.m., indicated Resident B's Left great toe was cleansed with wound cleanser, an antimicrobial foam dressing was applied to the wound bed and covered with a dry dressing. The nurse's note indicated eschar was noted and slough was around the eschar. The area surrounding the wound was reddened and warm to touch. Documentation was lacking for notification of the wound status to the POA. A nurse's note on 5/25/20 at 11:30 a.m., indicated Resident B's POA was aware of a new order. Documentation was lacking for notification of the changed wound status. A nurse's note on 5/26/20 at 12:19 p.m., indicated Resident B's POA was aware of a new order. Documentation was lacking for notification of the changed wound status. A Nurse Practitioner Progress Note dated 5/26/20 at 3:35 p.m., indicated a telehealth visit was done. Resident B's left great toe had necrosis present, [DIAGNOSES REDACTED] was noted to left foot and the resident was on antibiotic therapy. The progress note indicated the resident had mild confusion. The wound assessment indicated the wound on the great toe on the left foot was 4.5 cm (Centimeter, a measurement) x 6.5 cm, the depth was unable to be determined due to the dry eschar tissue. The 2nd wound on the left great toe measured 0.5 cm x 0.5 cm x 0.2 cm deep and had serous drainage. The skin had [DIAGNOSES REDACTED] surrounding both wounds on the left great toe. The NP ordered an Arterial and Venous Doppler to be done stat (right away) and treatment to continue with [MEDICATION NAME] ([MEDICATION NAME]-iodine, an antiseptic for skin disinfection) as ordered. The nurses' notes were lacking for notification to POA of the changed wound status with 2 open wounds on the left great toe. A nurse's note on 5/27/20 at 7:49 p.m., indicated the NP viewed the Doppler results. The note indicated to keep an eye on the leg and if any change in condition to send out for evaluation and treatment. The document was lacking for notification of the wound status and/or the NP order to go to the hospital if the wound looked worse. A nurse's note on 5/29/20 at 7:25 a.m., indicated POA was notified of a new order to do a urine dipstick check, a possible urinalysis and culture and sensitivity if needed. Documentation was lacking for notification of the change in wound status. A nurse's note on 5/30/20 at 4:16 p.m., indicated Resident B's left great toe was black and firm to touch, the skin was peeling in several layers and was white in color. There was a pin size hole draining a small amount of purulent (pus) drainage and blood. The nurse's note also indicated the wound status was noted and a Doppler was done. Instructions were to send to the emergency room for evaluation and treatment if condition worsens. Documentation was lacking for POA notification of the change in the wounds statues. A nurse's note on 5/31/20 at 9:02 a.m., indicated Resident B's left great toe was completely black and firm to touch. The black tissue was rescinding back into the foot. The left foot and leg were warm to touch. Resident B denied pain. The NP was notified and an order was given to send the resident to emergency room for evaluation and treatment. The nurses note also indicated the first contact (the POA) was notified, the resident was going to the hospital ER for evaluations. POA voiced concerns of possible amputation of the toe. A nurse's note on 5/31/20 at 10:32 a.m., indicated Resident B was transported to hospital for evaluation and treatment. An interview with the ADON (Assistant Directory of Nursing), and the facility's Wound Nurse on 7/9/20 at 12:45 p.m., indicated Resident B had resided in the Assisted Living (AL), and the resident was having multiple falls. She indicated the resident may have injured their toe when they fell in AL. Resident B was sent to the hospital for evaluation for the cause of increased falling. She indicated after discharge from the hospital, the resident returned to AL but could not manage there and was admitted to the Health Care on 5/20/20. She indicated the resident's left great toe was macerated and whitish in color at admission to health care. The ADON indicated the 3rd shift nurse documented, on 5/23/20, the resident's left great toe was red and swollen. The ADON also indicated the 1st shift nurse had documented the left great toe had eschar with slough on 5/23/20 and 5/24/20. She indicated during wound rounds on 5/26/20, Resident B had been seen by the Wound NP via Telehealth. The left great toe was black, the resident also had increased swelling in the left leg. The Wound NP ordered an arterial and venous Doppler to be done stat. The ADON indicated the nurse documented, Resident B's POA was notified the test was ordered. The ADON indicated resident's records did not have documentation the POA was notified of the changes in the wound status. She indicated the nurse had documented notification to Resident B of the wound status, but not the POA. The ADON further indicated Resident B's BIMS score was 13 but had cognitively declined since admission. She indicated the resident was informed of the Doppler results and the order to send to ER if the wounds became worse. The ADON indicated the POA was notified of the declined wound status when the Resident was going to be transferred to the hospital for evaluation and treatment. In an interview with the Administrator on 7/9/20 at 1:36 p.m., she indicated Resident B had a BIMS Score of 13, was cognitively intact, and the resident could be their own person for notifications. She provided the BIMS document which indicated the BIMS test was completed on 5/27/20 with the score of 13.

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

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) The Administrator also provided the documentation for the Wound NP progress note for the Telehealth visit on 7/26/20, due to the Coronavirus risk/restrictions in place. The note indicated the patient had a left great toe with necrosis present with plan to do an arterial and venous Doppler. The Administrator also provided the documentation for the First Contact notified on 5/31/20 at 9:02 a.m., of left great toe being completely black and firm to touch with black receding back into superior foot with the foot and leg warm to touch. The NP was contacted and orders received to send to ER for evaluation and treatment. Review of current facility policy, with a revision date of 11/21/16, titled, Notification of Changes (Resident Rights), was provided by the ADON on 7/9/20 at 1:45 p.m., indicated, .Residents, resident representative(s) and physicians at LLV (Lutheran Life Villages) will be notified of changes .Resident Representative: is an individual chosen by the resident to act on his/her behalf to support decision-making; access medical, social or other personal information; manage financial matters, receive notifications; a person authorized by State or Federal law to act on behalf of the resident in decision-making; access medical, social or other personal information; manage financial matters, receive notification; legal representative; court-appointed guardian or conservator .Procedure: 1. LLV will immediately inform the resident; consult with the resident's physician; and notify consistent with his/her authority, the resident representative(s) when there is a change as listed below: B. a significant change in the resident's physical, mental, or psychosocial status (that is a deterioration in health) .C. A need to alter treatment significantly (.a need to discontinue and existing form of treatment .or commence a new form of treatment) This Federal citation is related to IN 896 3.5-5(a)(2)