STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155461	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE VILLAGE NURSING AND REHABILITATION	**801 S SR 57 WASHINGTON, IN 47501**

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, treat, develop and implement a plan of care for a resident with recurring [MEDICAL CONDITION] of his feet, resulting in more than 1 hospitalization for [MEDICAL CONDITION]; and failed to assess and document the appearance of the resident's toes and feet; for 1 of 4 residents reviewed for skin impairments (Resident K). Findings include: On 7/31/20 at 10:15 A.M., the Director of Nursing Services (DNS) indicated Resident K had been admitted with an area of impaired skin to the buttocks. The DNS did not indicate the resident had any altered skin on the feet and/or toes. The clinical record of Resident K was reviewed on 8/3/20 at 10:50 A.M. [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment, dated 3/12/20, indicated the resident had a slight memory problem, required supervision of set up help for personal hygiene, and physical help of set up help for bathing. The resident had no venous or arterial ulcers, and no foot problems. Nurses Notes included the following notations: 5/10/20 at 7:54 A.M.: Resident very lethargic, shaking uncontrollably, weak and just a general change in condition, MD aware and new order to send to (name of hospital) ER for eval and tx (evaluation and treatment) 5/10/20 at 3:07 P.M.: (Name of hospital) called and admitted res (resident) [MEDICAL CONDITIONS] (skin infection) A hospital discharge summary, dated 5/13/20, indicated, Discharge Diagnosis: [REDACTED].Hospital course: May 11: .The patient does also report have (sic) [MEDICAL CONDITION] to his toes .Bilateral extremities were discolored and suggestive of chronic venous stasis .[MEDICAL CONDITION] of the left foot .Patient was given [MEDICATION NAME] (an antibiotic) and [MEDICATION NAME] (an antibiotic) in the ER and I will continue [MEDICATION NAME] The resident returned to the facility on [DATE] at 3:45 P.M. An Admission Observation form, dated 5/13/20 at 3:52 P.M., indicated Resident K had a skin impairment on his coccyx. Documentation of the appearance of his feet/toes at this time was not found. A plan of care to monitor the resident's feet was not found. Nurses Notes continued: 5/14/20 at 2:43 A.M.: .BLE (bilateral lower extremity) [MEDICAL CONDITION] (swelling) noted, [MEDICAL CONDITION] continues 5/16/20 at 11:44 P.M.: .(Name of antibiotic) continues for treatment of [REDACTED].The patient was recently hospitalized . The patient was noted to be [MEDICAL CONDITION] .for [MEDICAL CONDITION] of right (sic) great toe Nurses Notes continued: 6/4/20 at 2:47 A.M.: .res transferring with assist of 2 at this time, Res is unable to move right foot while transferring with staff 6/11/20 at 3:45 A.M.: .Res is unable to move right foot while transferring with staff 6/12/20 at 4:41 P.M.: Res not feeling well, lethargic, cant (sic) sit up at this time .99.1 T (temperature). Calling (name of physician). 6/12/20 at 9:41 P.M.: Res continues to be lethargic, skin is pale. T 99.3 .Notified (name of physician) order to send to (name of hospital) ER 6/13/20 at 12:13 A.M.: Resident admitted .with DX (diagnosis) of Metabolic [MEDICAL CONDITION] A hospital discharge summary, dated 6/14/20, indicated, Discharge Diagnosis: [REDACTED]. Suspect dementia .Chronic bilateral lower extremity wounds The resident returned to the facility on [DATE] at 6:19 P.M. An Admission Observation, dated 6/14/20 at 6:37 P.M., indicated the resident had no alterations in skin. A plan of care in regards to monitoring the resident's feet was not found. A quarterly MDS assessment, dated 6/30/20, indicated Resident K had a moderately impaired memory, required extensive assistance of one staff for personal hygiene, and total dependence of one staff for bathing. The resident had no venous or arterial ulcers, and no foot problems. A Nurses Note, dated 7/9/20 at 7:57 P.M., indicated, Resident very lethargic with slight elevated temp. This nurse notified MD et (and) N/O (new order) noted to send resident to (name of hospital) ER for eval et treatment A hospital history and physical, dated 7/9/20, indicated, Patient was recently admitted on ,[DATE] for .[MEDICAL CONDITION] of Left foot then admitted in 6/2020 for toxic/metabolic [MEDICAL CONDITION] with concern for [MEDICAL CONDITION] of Left foot .Physical Exam: 1+ [MEDICAL CONDITION] (swelling) of bilateral feet .Patient has [DIAGNOSES REDACTED] (redness) with dry flaking skin on left foot .Assessment/Plan: Toxic/Metabolic [MEDICAL CONDITION], suspected to be an acute infection .unknown source of infection but possibly related to his wounds .Multiple chronic wounds The resident returned to the facility on [DATE] at 1:04 P.M. A Nurses Note, dated 7/17/20 at 1:04 P.M., indicated, Resident returned to facility .extreme difficulty standing with walker, unable to straighten legs to standing position, per assist x 3 nursing staff to pivot to WC (wheelchair). Resident going to be hoyer lift until therapies can eval et tx as indicated .ATB (antibiotic) continues for [MEDICAL CONDITION] of L (left) great toe An Admission Observation, dated 7/17/20 at 2:12 P.M., did not indicate there was any impairment to the feet and/or toes. A plan of care regarding the resident's [MEDICAL CONDITION] and appearance of toe was not found in the clinical record. A wound assessment of the resident's left great toe was not found in the clinical record. A Physician's note, Date of service: 07/18/2020, indicated, .[MEDICAL CONDITION] to left great toe - [MEDICATION NAME] swab daily to affected area; p.o. (oral) antibiotics to continue course of treatment A physician's orders [REDACTED]. Nurses Notes included the following notations: 7/19/20 at 8:33 A.M.: .Skin issues noted on toe 7/22/20 at 7:11 A.M.: .Skin issues noted on toe A dietary note, dated 7/24/20, did not address the resident's toe. A Physician's note, Date of service: 07/24/2020, indicated, .[MEDICAL CONDITION] to left great toe - [MEDICATION NAME] swab daily to affected area; p.o. antibiotics to continue course of treatment Nurses Notes continued: 8/1/20 at 8:30 A.M.: .skin issues noted on L toe area A wound assessment of the resident's toes was not found in the clinical record. A care plan regarding the resident's toes was not found in the clinical record. On 8/3/20 at 2:15 P.M., a skin assessment was requested. LPN 2 indicated she did not work very much and was unfamiliar with the resident's skin. The resident was observed to be wearing protective shoes on each foot. LPN 2 was unsure which foot had wounds, and the resident pointed to his left foot. The resident was observed to be wearing socks, which appeared to be very snug, as LPN 2 had some difficulty removing them. Gauze dressings were observed on the resident's left great toe and left 2nd toe. The date on the dressings was illegible, but LPN 2 indicated she thought the date written was 8/7. LPN 2 indicated the date was probably the date that the dressings needed to be removed. The left great toe was reddened, with an open area on the outside of the toe. A scant amount of bloody drainage was observed on the dressing. The 2nd toe was also reddened, with an open area observed. A scant amount of bloody drainage was observed on that dressing. The resident's right foot had no open areas, but appeared discolored. On 8/3/20 at 2:25 P.M., LPN 1 was interviewed. LPN 1 indicated she performed the facility's wound assessments, and assessed the residents' wounds. When questioned regarding Resident K's wounds on his feet, LPN 1 indicated those areas were self-inflicted. Upon further interview, LPN 1 indicated she was unaware of any wounds on the resident's feet or toes, and was unaware of a treatment order to the toes. LPN 1 checked the resident's physician orders, and indicated there was an order for [REDACTED]. LPN 1 indicated there was no documentation for Resident K's areas, because she was unaware of the areas. The clinical record of Resident K was reviewed again on 8/4/20 at 9:30 A.M. A Nurses Note, dated 8/3/20 at 3:55 P.M., indicated, This nurse and DNS (Director of Nursing Services) assessed residents (sic) bilateral feet at this time, noted on right foot resident has discoloration on top of right foot near base of toes and on other right great toe, noted on left foot an area of impairment on top of left foot, red in appearance and superficial, also noted area of impairment on outer left great toe and on outer

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155461	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE VILLAGE NURSING AND REHABILITATION	**801 S SR 57 WASHINGTON, IN 47501**

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) second toe of left foot both areas dark red in appearance and superficial, (name of physician) notified at this time and order given to [MEDICATION NAME] areas on left foot until he assesses bilateral feet on 8/4/2020. Wound Management documentation included the following: Wound location: Left big toe. Date/Time Identified: 08/03/2020 04:04 PM .Length 2.6 (centimeters), Width 1.5 (centimeters), Wound healing status: Stable. MD to assess .Tx of [MEDICATION NAME] obtained for every shift. Wound location: Left top of foot. Date/Time Identified: 08/03/2020 04:02 PM .Length 3(centimeters), Width 3.2 (centimeters), Wound healing status: Stable. On 8/3/20 at 3:25 P.M., the DNS and LPN 1 provided the current facility policy, Skin Management Program, dated 4/2018. The policy included: Procedure for Alterations in Skin Integrity - Pressure and Non-Pressure 1. Alterations in skin integrity will be reported to the MD/NP, the resident and/or resident representative as well as to the direct care staff. 2. Treatment order will be obtained from the MD/NP. 3. All alterations in skin integrity will be documented on the admission observation in the medical record .4. All newly identified areas after admission will be documented on the New Skin Event. 5. The wound nurse will be notified of alterations in skin integrity. a) The wound nurse is responsible for communicating to IDT (interdisciplinary team) on a weekly basis .b) The wound nurse will complete the appropriate skin evaluation on the next business day. i) Wound Management for ulcers (arterial, diabetic, pressure or venous) will be updated until resolved .6. A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented This Federal tag relates to Complaint IN 655. 3.1-37(a)
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, interview, and record review, the facility failed to accurately assess and document the appearance of a pressure ulcer, for 1 of 3 residents reviewed with pressure ulcers (Resident H). Findings include: On 7/31/20 at 9:20 A.M., during the initial tour, the DNS (Director of Nursing Services) indicated Resident H had a long standing coccyx wound that was healed and then opened up again. Resident H was observed sitting in a Broda chair at that time. On 8/3/20 at 9:55 A.M., a wound assessment was requested. LPN 1 indicated she was the Wound Care nurse, who was responsible for the weekly wound assessments. Resident H was lying on an air bed. An open area, with some depth, was observed on the resident's coccyx area. The wound bed appeared red, with surrounding raised, white, calloused-like rolled tissue. The resident did not want to lie on her side for further assessment. LPN 1 indicated the pressure ulcer was a Stage 2. LPN 1 indicated she obtained a different treatment order the previous week, due to an increase in drainage. The clinical record of Resident H was reviewed on 8/3/20 at 10:05 A.M. [DIAGNOSES REDACTED]. A Care Plan, initially dated 5/8/20 and edited 7/31/20, indicated, Resident has impaired skin integrity: Stage 2 pressure ulcer to coccyx. The Approaches included: Assess wound weekly documenting measurements and description. Wound Management Documentation included: Date/Time Observed: 05/07/2020 at 1:07 P.M. Length (centimeters): 2.3 Width (centimeters): 2 Can depth be measured?: Yes Depth (centimeters): .2 Exudate (drainage) Amount: Light Exudate color and consistency: Serosanguineous (pale red to pink, thin and watery) Stage: Stage II (2) Percent of wound covered by granulation tissue: 25 Percent of wound covered by clean, non-granulation tissue: 75 Wound edges/margins: calloused/firm Skin surrounding wound: Pink/Normal Wound healing status: Declining Comments: MASD (moisture associated skin damage) around coccyx declined and now area is a stage 2, new tx (treatment) order given per MD, will continue to assess site daily and measure weekly. A Significant Change Minimum Data Set (MDS) assessment, dated 5/15/20, indicated Resident H had a short term and long term memory problem. Resident H had 1 Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer .). Wound Management documentation indicated the wound was measured weekly, and assessed as a Stage 2. Wound Management documentation, dated 7/27/20 at 10:23 A.M., indicated: Length (centimeters): 1.3 Width (centimeters): .9 Can depth be measured?: Yes Depth (centimeters): .2 Exudate (drainage) Amount: Heavy Exudate color and consistency: Serosanguineous (pale red to pink, thin and watery) Stage: Stage II Percent of wound covered by granulation tissue: 50 Percent of wound covered by clean, non-granulation tissue: 50 Wound edges/margins: calloused/firm Skin surrounding wound: Pink/Normal Wound healing status: Stable Comments: Area stable this week, area very wet and new order for tx change, for drawtex and change every other day. A physician's orders [REDACTED]. On 8/3/20 at 2:10 P.M., an additional wound assessment was requested. RN 1 and CNA 2 assisted the resident in rolling on her side. A dressing was removed, and a small amount of reddish drainage was observed. The wound bed had a scant amount of yellow tissue in the center, and appeared to be a greater depth than a Stage 2 pressure ulcer would be. RN 1 indicated LPN 1 had measured the pressure ulcer that morning. On 8/3/20 at 2:25 P.M., LPN 1 was interviewed. LPN 1 indicated she was unsure about the staging of the wound, and that a Corporate Nurse had looked at the wound and recommended it be documented as a Stage 2. She stated again that she had needed to change the treatment the previous week, due to the pressure ulcer draining more. On 8/3/2020 at 3:10 P.M., the DNS provided the most recent Wound Management report, dated 8/3/20 at 10:47 A.M. The report included: Length (centimeters): 1.3 Width (centimeters): .8 Can depth be measured?: Yes Depth (centimeters): .2 Exudate (drainage) Amount: Light Exudate color and consistency: Serosanguineous (pale red to pink, thin and watery) Stage: Stage II Percent of wound covered by granulation tissue: 50 Percent of wound covered by clean, non-granulation tissue: 75 Wound edges/margins: calloused/firm Skin surrounding wound: White or grey pallor Wound healing status: Improving Comments: Area slightly improved this week, will continue with current tx and current plan of care, will assess area daily and measure weekly. On 8/4/20 at 9:10 A.M., during an interview with the Corporate Nurse, she indicated she had discussed Resident H's pressure ulcer with LPN 1. She informed LPN 1 that if the area had a lot of drainage it was more than a Stage 2. On 8/3/20 at 3:25 P.M., the DNS and LPN 1 provided the current facility policy Skin Management Program, dated 4/2018. The policy included: Purpose: To promote the prevention of pressure ulcers/injury development; promote the healing of existing pressure ulcers/injuries and prevent development of additional pressure ulcer/injury .Pressure Injury: Is localized damage to the skin and underlying soft tissue usually over a bony prominence .Stage 2: Pressure Injury: Partial-thickness skin loss with exposed dermis .The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible .Stage 3: Pressure Injury: Full-thickness skin loss .in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present .Wound Management for ulcers (arterial, diabetic, pressure or venous) will be updated weekly until resolved .IDT (interdisciplinary team) will review residents with alterations in skin integrity weekly This Federal tag relates to Complaint IN 655. 3.1-40(2)