STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR GROVE VILLAGE	**1021 E CENTRAL AVE GREENSBURG, IN 47240**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's (Resident C) plan of care reflected current interventions for 1 of 3 residents reviewed for care plans. Findings include: The clinical record for Resident C was reviewed on 8/17/20 at 12:42 p.m. [DIAGNOSES REDACTED]. The care plan, dated 4/28/20, indicated the resident had an unstageable area to the right heel and was not to wear shoes until the area on the right heel was healed. On 8/18/20 at 12:14 p.m., staff were observed ambulating the resident from his room to the dining room. Tennis shoes were observed on both feet. During an interview on 8/18/20 at 12:18 p.m., the Director of Nursing indicated the resident's shoes should be removed after ambulating and it should be on the plan of care. The care plan lacked documentation of the removal of shoes after ambulation. On 8/18/20 at 1:44 p.m., the Director of Nursing provided a current copy of the document titled IDT (Interdisciplinary Team) Comprehensive Care Plan Policy, dated 10/2019. It included, but was not limited to, Policy: It is the policy of this facility that each resident will have a .person-centered care plan .The care plan will include .resident specific interventions based on resident needs .to promote the resident's highest level of functioning .Care plan .interventions will be updated based on changes in resident assessment/condition This Federal tag relates to Complaint IN 894 3.1035(d)(2)(B)
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 ensure a resident (Resident C) did not obtain a pressure ulcer for 1 of 3 residents reviewed for skin integrity. Findings include: The clinical record for Resident C was reviewed on 8/17/20 at 12:42 p.m. [DIAGNOSES REDACTED]. The significant change MDS (Minimum Data Set) assessment, dated 4/28/20, indicated the resident's cognition was severely impaired. The resident required the physical assistance of 2 staff members for bed mobility. The care plan, dated 1/3/12, indicated the resident was at risk for skin breakdown and to turn and reposition him every 2 hours as the resident allowed. On 5/13/20, the interventions were updated which included to float heels while in bed. The Braden Scale for Predicting Pressure Sore Risk, dated 3/10/20, indicated the resident was at risk due to very limited sensory perception, very limited mobility, and a potential problem of friction and shearing. On 4/21/20, the resident tested positive for COVID-19. The progress note, dated 4/28/20 at 3:05 a.m., indicated the resident had an unstageable pressure ulcer to the right heel which measured 2 cm (centimeters) length with a width of 2 cm. The center was black in color. The wound sheet, dated 4/28/20 at 10:28 a.m., indicated the wound was dark purple in color, measured 2 cm in length and 2 cm in width. The IDT (Interdisciplinary Team) note, dated 4/28/20 at 12:14 p.m., indicated the unstageable area to the right heel was necrotic and the periwound was dark. IDT had determined that the wound developed as a result of increased lethargy and bedridden due to his current infection (COVID-19). The clinical record lacked documentation of the resident being turned and repositioned or having his heels floated. On 8/18/20 at 1:28 p.m., the wound to the resident's right heel was observed to have a dark brown scabbed area and the wound edges were loose. The wound measured 1 cm in length with a width of 1.2 cm. During an interview on 8/18/20 at 12:18 p.m., the Director of Nursing indicated the resident had used his feet to push up in the bed. She was unaware the resident had used his feet to push himself up in the bed until staff reported it to her after the wound had developed. On 8/18/20 at 1:44 p.m., the Director of Nursing 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 .to prevent pressure ulcers and does not develop pressure ulcers .Avoidable Pressure Ulcer/Injury: means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the residents clinical condition .implement interventions that are consistent with resident needs This Federal tag relates to Complaint IN 894 3.1-40(a)(1)(2)

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.