STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155823	A. BUILDING 00 B. WING	03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHPOINTE HEALTHCARE CENTER	4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00348338 and Complaint IN00349438. Complaint IN00349438 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00348338 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686. Survey dates: March 17 and 18, 2021 Facility number: 013126 Provider number: 155823 AIM number: 300029591 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 15 Medicaid: 56 Other: 18 Total: 89 This deficiency reflects State findings in accordance with 410 IAC 16.2-3.1. Quality Review completed on March 23, 2021.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a complaint survey on March 18, 2021 Complaint #IN00348338. Please accept this plan of correction as the provider's credible allegation of compliance.	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to accurately assess pressure risks and implement preventative care for a newly admitted resident and failed to promptly implement treatment, resulting in the development of an unstageable pressure ulcer and an increase in size of the pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Findings include: On 3/17/2021 at 10:26 a.m., the closed clinical record of Resident B was reviewed. Diagnosis included, but were not limited to, fracture of the right femur, a need for assistance with personal care, peripheral vascular disease, and dementia. Resident B was admitted on 12/14/2020. An Admission Skin Evaluation, dated 12/14/2020, indicated Resident B was admitted with a surgical area on his right hip. No other skin issues were indicated. A Weekly Skin Check, dated 12/14/2020 (upon admission), indicated no skin conditions, no changes, and no ulcers, or injuries A Braden Observation Tool, dated 12/14/2020,	F 0686	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? ***Resident B discharged from the facility on 2.20.21*** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? ***All residents will be evaluated to determine risk factors by using the Braden observation tool. For those residents identified at risk for development of pressure ulcers, individualized prevention interventions will be defined on the resident's care plan and implemented. For all residents currently identified with pressure ulcers, treatment orders will be reviewed by wound nurse and wound MD to ensure that appropriate orders are in place and modify as indicated.*** What measures will be put into	04/09/2021

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	indicated Resident B was at low risk for Pressure Ulcers. The clinical record lacked a completed Admission Observation Tool, identifying skin impairments at the time of admission. An admission Minimum Data Set (MDS) assessment, dated 12/20/20, indicated Resident B's cognitive status was moderately impaired. Resident B did not have any pressure ulcers, was at risk for developing pressure ulcers, and required extensive assistance with bed mobility. Current skin and pressure reducing treatments implemented were a pressure reducing device for a chair and a pressure reducing device for a bed. The Turning/Repositioning Program was left blank. A Care plan, (undated), indicated Resident B had a performance deficit, required assistance with activities of daily living related to femur (fracture), and dementia. The care plan lacked interventions related to wound prevention or wound care. A Physical Therapy note, dated 12/22/2020 (8 days after admission), indicated "a skin check reveals approx [approximately] 1/2 dollar heel wound unstageable with 70% brown eschar (dead skin) at center and light pink wound borders." The Medical Director was notified and an order was received for offloading boots at all times. A Physicians order, dated 12/31/2020 (9 days after pressure ulcer identified), indicated "Cleanse wound to left heel with NS [normal saline], apply Betadine, cover with ABD (abdominal gauze pad) and wrap with kerlex [sic]." A Skin Grid Pressure, dated 1/4/2021 [late entry for		place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The facility staff strives to prevent resident skin impairment and to promote the healing of existing wounds. The Admission Nurse/designee will complete a Braden Observation Tool and Admission Skin Evaluation for all new residents upon admission and then develop a care plan with individualized interventions to address risk factors. All residents will be evaluated by a licensed nurse for changes in skin condition weekly as well as to identify risk indicators quarterly and with change of condition. For those residents identified at high risk for development of pressure ulcers, individualized prevention interventions will be defined on the resident's care plan, implemented and revised as appropriate. For those residents who develop a pressure ulcer, an appropriate treatment will be immediately initiated per physician's order. The DON and/or Wound Nurse will educate licensed nursing staff on accurate completion of the Admission Skin Evaluation, Braden Observation Tool and Weekly Skin Check Tool as well as obtaining a physician order for wound care treatments to be***	

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	12/31/2020 as indicated by the Director of Nursing], indicated "a new pressure area on [Resident B's] left heel, the area measured 5.0 cm x 6.0 cm x 0.1 cm, unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by eschar in the wound bed.) Community Acquired. Diagnosis/Additional Risk Factors: Resident admitted with a 5.0 x 6.0 x 0.1 unstageable pressure wound to left heel." However, the clinical record lacked an admission assessment for a wound on the left heel and/or documentation wound was present on admission and though 12/22/2020. A Dietary Progress Note, dated 1/6/2021 (15 days after pressure ulcer identified), indicated "wound to left heel is unstageable. Medications reviewed, Registered Dietician recommended ...2. add promode [sic/liquid protein] and Vitamin C to promote wound healing." A Skin Grid Pressure, dated 1/18/21, indicated "...3. date area was first observed: 1/4/2021 Site: Left Heel Type: Pressure, Length 4.2 cm x 4.8 cm x 0.1 cm. Stage: unstageable." A wound care provider note, dated 2/01/2021, indicated Medical History: "Positive for history of pressure wounds, left heel." A Skin Grid Pressure, dated 2/15/21, indicated "...3. date area was first observed: 1/4/2021 Site: Left Heel Type: Pressure, Length 5.5 cm x 4.0 cm x 0.2 cm. Stage: unstageable." A skin/wound note, dated 3/3/2021, indicated "correction noted from wound notes: Pressure area to left heel is not a new area, wound was present upon admission per wound MD [Medical Doctor]."		***promptly implemented upon identification of a new pressure ulcer.*** How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)? ***The following audits and/or observations for 8 residents will be conducted by the DON/designee twice weekly for 6 weeks, once weekly for 2 weeks and then monthly for 4 months: 1) completion of Admission Skin Evaluations, Weekly Skin Checks and Braden Observation Tools per facility policy 2) Residents identified with wounds will be reviewed to ensure an appropriate treatment is in place 3) Residents identified as high risk for developing pressure areas will be monitored to ensure that individualized prevention interventions are implemented per resident's care plan.*** ***The results of the audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.***	

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The clinical record lacked documentation of a care plan related to the assessed unstageable pressure wound identified on 12/22/2020.

During an interview, on 3/17/2021 at 1:22 p.m., the Director of Nursing, indicated Resident B was admitted with a pressure ulcer on his left heel. The DON is unsure why the wound was not observed on the day of admission. "It was missed." The Director of Nursing was unable to provide documentation to indicate the wound was present upon admission nor additional documentation of a developed plan of care for the wound.

During an interview, on 3/18/2021 at 8:50 a.m., the Director of Nursing, indicated, on 12/31/2021 the Physical Therapist observed no improvement to the left heel and notified the Physician. A new order for normal saline was obtained. "It was New Year's Eve." The therapist did not document the skin assessment until 1/4/2021, 4 days after the assessed pressure ulcer.

On 3/18/2021 at 8:45 a.m., the Director of Nursing provided a policy titled: Skin Care and Wound Management Overview, dated 4/20/2017, and indicated it was the current policy being used by the facility. A review of the policy, indicated "Policy: the facility staff strives to prevent resident/patient skin impairment and to promote healing of existing wounds....The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Procedure:...2. Complete an Admission Observation Tool. Identify areas of skin impairment and pre-existing

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	signs....6. Monitor and document progress...." This Federal tag relates to complaint IN00348338. 3.1-40(a)(1) 3.1-40(a)(2)			