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F 000	INITIAL COMMENTS	F 000	Please see attached.	
Ok Lg ✓	Correction date: 3/20/2024 The following deficiencies resulted from investigation of complaints #118595-C, #118737-C, #118876-C and facility reported incidents #117942-I, #118234-I, and #118551-I conducted February 15, 2024 - February 27, 2024. Complaints #118595-C and #118876-C were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: ✓ 3/22/2024

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.

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(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interview and facility policy review the facility failed to implement a comprehensive care plan for 1 of 3 residents (Resident #5) reviewed for elopement. The facility reported a census of 110 residents.

Findings include:

The admission Minimum Data Set (MDS) assessment tool with a reference date of 2/13/24 documented Resident #5 had a Brief Interview of Mental Status (BIMS) score of 4. A BIMS score of

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4 suggested severe cognitive impairment. The MDS documented he had an admission date of 2/9/24. Resident #5 exhibited wandering behavior daily during the review period. He needed partial assistance from another person for indoor mobility, had impairment to both of lower extremities and utilized a walker. Resident #5 required supervision or touching assistance to walk 50 feet with two turns. The MDS documented he had the following diagnoses: metabolic encephalopathy, diabetes mellitus, dementia, anxiety, and chronic obstructive pulmonary disease.

The Care Plan focus area with an initiation date of 2/13/24 documented Resident #5 was alert and oriented to person due to his diagnoses of dementia/encephalopathy. His mood varies from ok to angry, he had behavioral expressions of resistance with cares and elopement issues. The care plan lacked interventions for staff to utilize. The care plan also lacked Resident #5 had a wander guard, interventions for staff to utilize if he displays wandering behaviors. The care plan also lacked his exit seeking behaviors and interventions for staff to utilize to prevent him from eloping. The care plan also failed to include when he eloped on 2/13/24 and interventions for staff to utilize to ensure he did not elope.

The Elopement Assessment dated 2/9/24 documented he did not have an elopement risk.

The Treatment Administration Record (TAR) for February 2024 contained the following order: check wander guard for placement and functioning every shift, for wandering, with a start date of 2/9/24.

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The Progress Notes documented the following:
a) On 2/11/24 at 8:17 AM resident very anxious and restless. He continued to pace the halls, setting off the door alarms, seeking to exit, and stating he wanted to go home. Resident #5's significant other called three times to talk to him but he continued to attempt to elope, and went in to other resident's rooms. Staff redirected, toileted, offered drinks and something to eat but these interventions did not help for a long time as he began to pace the halls again.
b) On 2/12/24 at 8:03 PM resident continues to pace the hall this shift, setting off the door alarms, going in to other resident's rooms and going through their stuff. Staff redirected each time with difficulty as he would attempt to hit other residents and staff. He would take his clothes off and come out in the hallway with only his depends on. Resident #5 stated he wants to go home, highly exit seeking behavior noted. His significant other called three times to talk to him, to calm him down but that did not work for too long. Resident finally laid down in his bed and went to this this morning.
c) On 2/13/24 at 7:17 AM resident on follow up for behaviors and wandering. Resident pleasant this shift but very confused. Easily redirected, did not sleep this shift. He did attempt to open the door at the end of the hall by the old activity room and set off the alarm while looking for the stairs. Resident reassured there were no stairs in the building and successfully redirected him.
d) On 2/13/24 at 9:00 AM staff saw Resident #5 in the parking lot and brought him back into the facility. He may have gone outside through the hall's exit door. Exit door alarming. When he eloped, staff working on his hall were busy assisting other residents in the rooms.
e) On 2/13/24 at 12:53 PM nurse notified that

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resident had exited outdoors this morning at approximately 7:30 AM this morning. The door and wander guard alarms both sounded. Staff members responded to alarms appropriately and began to search. Two staff members went outside of the door that had alarmed while other staff members searched rooms inside. While outside, a unit manager had arrived to work, observed him and brought him immediately inside. He denied pain and no injuries noted after an assessment completed. Resident #5 placed on one to one supervision with a Certified Nursing Assistant (CNA). While interviewing staff regarding the incident, the CNA performing one to one supervision stated the resident observed staff coming in the employee entrance and attempted to go out that door. Resident immediately redirected and is now with activities for one to one supervision.

f) On 2/13/24 at 10:00 PM resident had one on one care this evening. He continued to pace the halls, going to other units with his staff member. He went to the dining room for supper. Resident #5 attempted to reach for exit door but was timely redirected away from the door. No elopements this shift.

On 2/15/24 at 11:55 AM observed the resident sitting in his recliner in his room, looking out the window. Resident had a wander guard on his left wrist.

On 2/15/24 at 1:35 PM Staff F CNA stated she heard the alarm go off the morning Resident #5 left the building. Staff rushed to the door, she was in the dining room and went back to the hall to see what was going on. He was not on one to one supervision at that time. He later tried to go out again while he was on one to one supervision.

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On 2/15/24 at 1:51 PM Staff D Certified Medication Aide (CMA) stated they would take Resident #5 to the bathroom, see if he wanted something to drink when he would start wandering.

On 2/15/24 at 2:00 PM Staff B Licensed Practical Nurse (LPN) stated that Resident #5 very confused, had dementia and kept trying to elope. At about 7:30 AM he went out the door. While he was with Staff E he tried again to leave the building but staff redirected. After they got him back inside they had him under one to one supervision with activity staff. She stated the resident not appropriate for their facility, he tried to hit staff and other residents. She believed there was 40-50 residents on his hall and felt they need more staff if they have those kinds of residents with behaviors.

On 2/15/24 at 2:12 PM Staff E CNA stated the day he eloped he was one to one supervision after he eloped until activities staff took over. While staff one to one with him, he saw staff leaving so he tried to leave that way too but staff able to redirect him.

On 2/15/24 at 2:40 PM Staff C LPN stated when he admitted she asked him to stay in his room while she stepped out to get something. He came out of his room and thought he looked like a wanderer, followed her and redirected him while she tried to go in to another room. Staff A put a wander guard on him that day. Over that weekend he was at the exit door so staff kept an eye on him. He would get in other resident's faces to hit them, when Staff C would step in the middle of it he tried to slap her twice. At this time, he was

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not on one to one supervision. When asked what interventions were in place for him she stated they kept him in front of the nurse's station before they did the one on one supervision. He had only eloped that one time.

On 2/15/24 at 2:56 PM Staff A Registered Nurse (RN) stated she was at the facility when Resident #5 was admitted. After he was taken to his room, she noted he was already walking around, needing some attention. She went to her Director of Nursing (DON) about his wandering. Staff A told her she needed a wander guard for Resident #5, when she was questioned about this she told the DON she believed he needed one because he was already walking all over. She felt he could get out of the building and she wanted that alarm to tell her and staff if he was getting close to the door. Once she got the wander guard and order she put it on his right wrist. That night he was wandering around, he would not sleep or lye down. They offered taking him to the bathroom, a drink and snack but nothing was working to keep him calm. That night her and the two CNAs kept a close eye on him to keep him safe. Staff A indicated they used to have a dementia unit but closed it. That unit would have been appropriate for Resident #5.

On 2/16/24 at 8:53 AM Staff G stated on the day Resident #5 eloped, she was walking in to the building for work when she noticed someone was by the staff entrance. Resident #5 was walking from the building, a few steps from the emergency exit door. She was not sure where this person was going so she went over to see who it was. He stated he was confused and trying to get to his room. She told him to come with her and she would show him where he lived.

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On 2/16/24 at 9:35 AM the DON stated since Resident #5 had been admitted he was pretty restless and had behaviors that included aggression, agitation and he eloped. He would wander in and out of other resident's rooms and had door seeking behavior since he was admitted. Staff were to redirect these behaviors and that appeared to help. They also put a wander guard on him, kept an eye on him and had him up at the nurse's station a lot. She was not in the building the morning he eloped but arrived shortly after. She indicated he did not elope because her staff followed the facility's process, they put him on one to one, staff were educated. She indicated staff immediately went outside when they heard the alarms sounding, did a head count and Staff G had him and brought him back inside. When asked what her definition of elopement was, she stated if staff did not follow their process, if the alarms sounded and they did not go meet him, if a head count was not completed, and did not look for him. She again stated Staff G saw him and grabbed him, he had just come out of the door. When asked what staff had eyes on him the whole time she again stated Staff G did when he came out the door. When asked if staff was physically with him from the time he left his room until he went outside, she stated Staff G got him, staff did not follow him out the door. At the time he left the building staff were closely observing him but afterwards he was on one to one supervision. The DON was informed the use of a wander guard, his exit seeking behaviors and his elopement was not care planned. When asked if this kind of information should be on his care plan she shook her head yes and acknowledged it should be care planned. She added not everything was done yet like

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F 656	Continued From page 8 getting his care plan updated. The facility's Comprehensive Care Plan policy with an implementation date of 10/24/22 documented it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policy review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of	F 658		

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practice regarding signing out ointment treatments as being completed and initiating physician's orders for 2 or 3 residents reviewed (Resident #4 and #11). The facility reported a census of 110.

Findings include:

1) The annual Minimum Data Set (MDS) assessment tool with a reference date of 1/7/24 documented Resident #4 had a Brief Interview of Mental Status (BIMS) score of 2. A BIMS score of 2 suggested severe cognitive impairment. The MDS listed the following diagnoses: dementia, hypertension, peripheral vascular disease, and benign prostatic hyperplasia.

The Care Plan focus area with an initiation date of 1/12/24 documented Resident #4 had a communication problem related to confusion, short-term memory and dementia. The care plan directed staff to monitor for presence or absence of symptoms such as fever, cough and shortness of breath. Resident #4 tested positive for COVID-19 on 11/16/23. Staff directed to promptly report any of the following: trouble breathing, oxygen saturation below 90% , persistent pain or pressure in his chest, new confusion or inability to around, and/or bluish lips or face. Staff also directed to report any worsening symptoms or lack of improvement from treatments to the physician or designee.

The Care Plan focus area with an initiation date of 1/12/24 documented he had shortness of breath and wheezing post COVID-19. Staff were to monitor/document breathing patterns, report abnormalities to his physician: nasal flaring, respiratory depth charges, altered chest

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excursion, use of accessory muscles, pursed-lip breathing or prolonged expiratory phase, increased anteroposterior chest diameter.

The Progress Notes documented the following:
a) On 1/22/24 at 1:12 PM resident is wheezing this shift, pulse oxygen saturation at 91% on room air. Resident is not short of breath or respiratory distress noted or reported. An albuterol treatment was given and will continue to monitor.
b) On 1/23/24 at 2:33 PM resident continues with a non-productive cough. Resident #4 required his as needed cough syrup with effectiveness. His lungs are diminished to auscultation bilaterally, respirations easy and unlabored with no expiratory wheezing noted. He denied any shortness of breath, cough is chronic for him, and afebrile. Staff will continue to monitor for any change in status. At 7:55 PM wheezing remains heart rate at 100 beats per minute, respirations at 22, oxygen saturation at 90%. His as needed (PRN) nebulizer was given at 4:28 PM. His lung sounds remained coarse all over with distance expiratory wheezes, no coughing: respirations at 20, heart rate at 92 and oxygen saturation at 94% on reassessment.
c) On 1/24/24 at 1:09 PM a Certified Nursing Assistant (CNA) brought resident back form lunch stating resident had trouble swallowing food and appears to not be himself: his eyes are closed, will open when spoke to, his oxygen saturation is 89-90% on room air. His PRN cough syrup was given for chest congestion. Staff received an order to continue observation and call tomorrow with any update, if oxygen saturation gets below 87% to call the provider.
d) On 1/24/24 at 4:30 PM Resident #4 transported to the hospital for shortness of

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breath, wheezing and chest congestion.
e) On 1/24/24 at 10:32 PM Resident #4 returned to the facility from the Emergency Room (ER) at about 10:10 PM. Hospital nurse only reported that his chest x-ray and respiratory studies were normal with the exception of the fluids in his throat which they tried to suction but he became very combative and were unable to completed the task. Please see paper work for the hospital on the clip board.

Review of a document titled After Visit Summary dated 1/24/24 documented Resident #4 to start taking Guaifenesin (expectorant) commonly known as Mucinex, 600 milligrams (mg) two times, daily for five days. The After Visit Summary lacked documentation of a time and notation by a nurse.

Review of Resident #4's January 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed it did not include the following order: Guaifenesin 600 mg two times a daily for five days.

On 2/21/24 at 1:10 PM informed the Director of Nursing (DON) of the Guaifenesin order not being started after recommended to be started by the ER on 1/24/24. The After Visit Summary reviewed with the DON and the chest x-ray results were noted on 1/25/24 and she questioned if the summary itself was timed and noted. During a follow-up interview on 2/27/24 at 2:13 PM the DON stated she talked with staff about the order not be initiated and they should have initiated it upon return from the hospital.

2) The admission Minimum Data Set (MDS)

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assessment tool with a reference date of 12/11/23 documented Resident #11 had a Brief Interview of Mental Status (BIMS) score of 9. A BIMS score of 9 suggested she had mild cognitive impairment. An admission date was documented at 12/7/2023. Resident #11 did not exhibit rejection of care during the 7-day review period. The MDS documented Resident #11 at risk for the development of pressure ulcers/injuries and had no unhealed pressure ulcers/injuries. Resident #11 had moisture associated skin damage (MASD), had a pressure reducing device for her chair and bed, was not on a turning/repositioning program, did not utilize nutrition or hydration interventions to manage skin problems and had ointments/medication other than to her feet. The following diagnoses were listed: stroke, cancer, diabetes mellitus, hemiplegia, seizure disorder, anxiety, morbid obesity, and body mass index (BMI) 50.0-59.9.

The Care Plan focus area with an initiation date of 12/13/2023 documented the resident at risk for skin breakdown due to diabetes, immobility and incontinence. The care plan directed staff to administer treatments as ordered and to monitor for effectiveness. Staff are to follow facility protocols for the prevention/treatment of skin breakdown. Resident #11 utilized a pressure reducing mattress to her bed and cushion in her chair.

Review of Resident #11 orders revealed the following order with a start date of 12/7/23 and end date of 2/15/23: cleanse resident's buttocks with soap and water, apply a layer of Z-guard paste every shift for skin integrity. The paste is to be applied during the day, evening and night shifts.

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Review of the December 2023 Treatment Administration Record (TAR) revealed the order not signed out as being completed on:
a. 12/10/23 day shift,
b. 12/13/23 night shift,
c. 12/15/23 day and evening shifts,
d. 12/16/23 evening shift,
e. 12/17/23 day shift,
f. 12/20/23 day shift,
g. 12/21/23 day shift,
h. 12/22/23 day shift,
i. 12/26/23 day, evening and night shifts,
j. 12/27/23 night shift,
k. 12/28/23 day shift,
l. 12/29/23 evening shift and
m. 12/30/23 evening and night shifts.

Review of the January 2024 TAR revealed the order not signed out as being completed on:
a. 1/2/24 evening shift,
b. 1/3/24 day shift,
c. 1/4/24 day and evening shifts,
d. 1/5/24 day and evening shifts,
e. 1/9/24 day and evening shifts,
f. 1/12/24 day shift,
g. 1/13/24 evening shifts,
h. 1/15/24 day shift,
i. 1/16/24 evening shift,
j. 1/18/24 evening shift,
k. 1/19/24 evening shift,
l. 1/20/24 day shift,
m. 1/22/24 day shift,
n. 1/23/24 day shift, and
o. 1/26/24 evening shift.

Review of the February 2024 TAR revealed the order was not signed out as being completed on:
a. 2/14/24 night shift.

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F 658	Continued From page 14 On 2/22/24 at 11:31 AM the Director of Nursing (DON) informed Resident #11's Z-guard cream not signed out as being completed. Presented the DON with the TARs and she said awesome. When asked who completed those treatments she stated the nurses do those. During a follow-up interview with the DON on 2/27/24 at 2:13 PM she stated something should have been documented on the TAR. The TAR has different codes for different reasons why the order was not completed: out of the facility, refuses, etc. The facility's Medication and Treatment Orders Policy with a revision date of July 2016 documented orders for medications and treatments will be consistent with principles of safe and effective order writing. The facility's Documentation of Medication Administrator policy with a revision date of April 2007 documented the facility shall maintain a medication administration record to document all medications administered. 1. A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given.	F 658		
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		

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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.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interviews, provider interviews and facility policy review the facility failed to provide skin assessments per policy and provide treatments per physician's orders to prevent the development and worsening of a facility acquired pressure ulcer which required the physician to complete a debridement of a Stage IV pressure ulcer to the coccyx for 1 of 3 residents (Resident #11) reviewed for pressure ulcers. There was an immediate need for the facility to take steps to ensure residents were protected from risk of development or worsening of wounds. The facility reported a census of 110 residents.

On February 22, 2024 at 3:05 PM, the State Survey Agency informed the facility of the staff's failure to assess and provide treatments per physician's orders created an Immediate Jeopardy situation resulting in the development of a Stage IV pressure ulcer as discovered on February 14, 2024. The facility staff removed the immediacy on February 23, 2024 at 1:37 PM when the staff implemented the following Corrective Actions:
The facility took the following actions to address the citation and prevent any additional residents

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from
suffering an adverse outcome. (Completion Date: 16 Feb 2024)
a) The Director of Nursing (DON) and designee(s) conducted skin assessments on all residents. Concerns were not identified.
b) An audit was conducted to ensure all treatments, supplies, and equipment were readily available for
ordered wound treatments by Nursing Supervisors and designee(s).
c) A medical records review was completed on all residents by Nursing Supervisors and designee(s) to
ensure weekly skin assessments were completed and treatment recommendations/orders were in place.

The facility took the following actions to prevent an adverse outcome from reoccurring: (Completion Date: 22 Feb 2024)
a) The facility policies on Skin Assessment and Pressure Injury Prevention and Management were
reviewed and revised as needed.
b) An audit of all pressure relieving devices and support surfaces was conducted by the Nursing Supervisor(s) to ensure proper use.
c) The DON or designee provided education to all licensed nurses on facility policies and procedures related to skin/wound care, as well as appropriate wound treatment measures. This included ensuring residents had necessary support surfaces and pressure relieving devices.
d) The DON or designee educated all nurse aides on preventative skin care.
e) The DON or designee conducted treatment record and nursing documentation audits 5 days a

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week to ensure accurate and complete documentation of skin related treatments and preventative measures.
f)The DON or designee will continue to monitor/audit 3 residents each week for the following: 1)Observation of treatments
2)Preventative skin care
3)Weekly skin assessments
g) A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings
from the PIP will be presented at the monthly

The scope lowered from a "J" to a "D" at the time of the survey after ensuring the facility implemented education, their policy and procedures.

Findings include:

The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:

Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not

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obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.

Unstageable Ulcer: inability to see the wound bed.

Other staging considerations include:

Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (unstageable, stage 3, or stage 4). Do not use DTI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

The admission Minimum Data Set (MDS)

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assessment tool with a reference date of 12/11/23 documented Resident #11 had a Brief Interview of Mental Status (BIMS) score of 9. A BIMS score of 9 suggested she had mild cognitive impairment. An admission date was documented at 12/7/2023. Resident #11 did not exhibit rejection of care during the 7-day review period. The MDS indicated Resident #11 was at risk for the development of pressure ulcers/injuries and had no unhealed pressure ulcers/injuries. Resident #11 had moisture associated skin damage (MASD), had a pressure reducing device for her chair and bed, was not on a turning/repositioning program, did not utilize nutrition or hydration interventions to manage skin problems and had ointments/medication other than to her feet. The MDS documented her weight in pounds was 327 and was 64 inches tall. The following diagnoses were listed: stroke, cancer, diabetes mellitus, hemiplegia, seizure disorder, anxiety, morbid obesity, and body mass index (BMI) 50.0-59.9.

The discharge-return anticipated MDS assessment tool with a reference date of 2/16/24 documented Resident #11 had severely impaired cognitive skills for daily decision making. She did not exhibit rejection of care during the 7-day review period. She was dependent on staff for toileting hygiene, showering, dressing, chair/bed to chair transfer. The MDS documented she had an unhealed stage 4 pressure ulcer/injury that was not present upon admission.

The active diagnoses portion of the Electronic Health Record (EHR) of Resident #11 documented diagnoses of: hemiplegia (paralysis of one side of the body) affecting left dominant side, muscle weakness, reduced mobility, need

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for assistance with personal care, seizures, malignant neoplasm of endometrium, anxiety disorder, atrial fibrillation, lymphedema, morbid obesity, obstructive sleep apnea, BMI 50-59.9, spinal stenosis, type 2 diabetes mellitus, vitamin D deficiency, cerebral infarction due to thrombosis of right cerebellar artery.

The Baseline Care Plan for Resident #11 dated 12/7/2023 documented the following skin integrity issues: slight redness to groin, abdominal folds, and groin. Her bilateral lower extremities and feet dry and scaly.

The Comprehensive Care Plan of Resident #11 initiated 12/13/2023, identified a Focus Area of an Activities of Daily Living (ADL) self care performances deficit related to hemiplegia, impaired balance, limited range of motion and stroke. The Care Plan indicated she required two staff members to reposition and turn in bed. Staff directed to use a mechanical lift for transferring and two staff members. She is totally dependent on staff for bathing and toileting. A second Focus Area documented she is at risk for skin breakdown due to diabetes, immobility, and incontinence. Staff directed to administer treatments as ordered and monitor for effectiveness. Staff also encouraged to follow facility protocols for prevention/treatment of skin breakdown. The care plan documented she had a pressure reducing cushion in her chair and mattress on her bed. A Focus Area with an initiated date of 2/18/24 documented she had a stage IV pressure ulcer to her coccyx. Staff directed to measure length, width, and depth where possible. Assess and document the status of wound perimeter, wound bed and healing progress and report improvements and declines

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to the physician. Staff to consult the wound specialist as ordered and his physician will see her in the facility. Staff to encourage frequent repositioning. Resident #11 will require supplemental protein, amino acids vitamins, minerals as ordered to promote wound healing. While completing dressing changes staff to monitor the wound for signs and symptoms of infection/worsening (redness, increased pain/tenderness/drainage, edema, warmth). Resident #11 had a low air loss mattress placed.

The following Braden scales for predicting pressure sore risk completed as following:
-On 12/7/23 at 7:37 PM documented a score of 13, indicating Resident #11 was at moderate risk for developing pressure sores
-On 2/14/24 at 10:00 PM documented a score of 13, indicating resident #11 was at moderate risk for developing pressure sores
-On 2/15/24 at 1:01 PM documented a score of 10, indicating Resident #11 was at high risk for developing pressure sores

The Admission Assessment dated 12/7/23 at 5:21 PM documented slight redness to abdominal folds, bottom and groin with treatment in place. Bilateral lower extremities and feet dry and scaly.

The admission Skin One Time Observation Tool dated 12/7/23 at 7:39 PM documented the following impaired skin areas: slight redness to her groin, abdominal folds and bottom; bilateral lower extremities and feet dry and scaly.

The total body skin assessments completed on 12/22/23, 12/29/23, 1/5/24, 1/9/24, 1/12/24, 1/19/24, 1/26/24, and 2/2/24 documented "0" when asked to enter the # of new wounds.

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The plan of care response history review completed on 1/29/24, 2/4/24, 2/5/24, 2/6/24, 2/7/24, 2/8/24, 2/11/24, 2/12/24, 2/13/24, and 2/15/24 instructed staff to complete skin observations and notify the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care. Staff documented yes when asked if an observation of resident's skin completed.

The Skin and Wound Evaluation dated 2/15/24 at 9:21 AM documented it was still in progress. The evaluation documented Resident #11 had a new Stage III: full-thickness skin loss, pressure ulcer on her intergluteal cleft (butt crack) that was acquired in-house with the following measurements 43.9 centimeters (cm) x 10.2 cm x 6.9 cm. The depth, undermining, and tunneling were not applicable.

Review of Resident #11 orders revealed the following order with a start date of 12/7/23 and end date of 2/15/23: cleanse resident's buttocks with soap and water, apply a layer of Z-guard paste every shift for skin integrity. The paste is to be applied during the day, evening and night shifts.

Review of the December 2023 Treatment Administration Record (TAR) revealed the order not signed out as being completed on:
a. 12/10/23 day shift
b. 12/13/23 night shift
c. 12/15/23 day and evening shifts
d. 12/16/23 evening shift
e. 12/17/23 day shift
f. 12/20/23 day shift
g. 12/21/23 day shift

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h. 12/22/23 day shift
i. 12/26/23 day, evening and night shifts
j. 12/27/23 night shift
k. 12/28/23 day shift
l. 12/29/23 evening shift
m. 12/30/23 evening and night shifts

Review of the January 2024 TAR revealed the order not signed out as being completed on:
a. 1/2/24 evening shift
b. 1/3/24 day shift
c. 1/4/24 day and evening shifts
d. 1/5/24 day and evening shifts
e. 1/9/24 day and evening shifts
f. 1/12/24 day shift
g. 1/13/24 evening shifts
h. 1/15/24 day shift
i. 1/16/24 evening shift
j. 1/18/24 evening shift
k. 1/19/24 evening shift
l. 1/20/24 day shift
m. 1/22/24 day shift
n. 1/23/24 day shift
o. 1/26/24 evening shift

Review of the February 2024 TAR revealed the order not signed out as being completed on:
a. 2/14/24 night shift

The Occupational Therapy (OT) Discharge Summary with a date of service of 12/8/23-1/4/24 documented an Assessment and Summary of Skilled Services: trialed multiple interventions to promote out of bed activity. Resident able to tolerate an average of 15 minutes of sitting in her wheelchair before requesting to go back to bed. Trialed sitting unsupported, averaging about 5 minutes of sitting with minimum to moderate assistance. Resident dependent with peri cares

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and toileting due to inability to tolerate out of bed activity. Discharge Recommendations and Status: recommend 15-20 minutes of sitting in wheelchair with the use of the mechanical lift to transfer.

The Physical Therapy (PT) Discharge Summary with a date of service of 12/8/23-1/4/24 documented a Discharge Recommendations and Status: resident requires assistance for all ADL's and is dependent on staff for all functional mobility to prevent skin breakdown.

The Progress Notes documented the following:
a) On 2/14/24 at 10:00 PM the charge nurse called asking this nurse to come to Resident #11's hall right away. The charge nurse for unit stated that she had a skin issue she would like for this nurse to look at. They entered the resident's room and two Certified Nursing Assistants (CNAs) were present providing peri cares to resident. Resident turned on her left side. Charge nurse stated that she would like for this nurse to see resident's bottom. This nurse assessed peri-rectal area. Resident had a pressure area the size of a baseball with undetermined depth/tunneling to coccyx site. Edges are irregular and macerated. Wound bed with dark red, black tissue present. Serosanguinous (bloody drainage) drainage noted to site with other areas of excoriation surrounding wound. Current treatment regimen that has been in place to site since admission is Z-guard ointment to site. Z-guard treatment discontinued as it was no longer effective for deteriorated site. Treatment initiated as follows to coccyx: (1) cleanse site; (2) apply skin prep to intact skin surrounding site; (3) pack wound with saline soaked gauze; (4) cover with protective dressing every shift and as needed (PRN). Order

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written to have wound assessed/followed by the physician who will be in house tomorrow. Resident not on an air mattress and will need one due to the wound. Staff educated that resident is to be turned and repositioned frequently off-loading off of bottom as much as possible and is also to be checked and changed frequently. Resident incontinent of urine and consideration may need to be suggested for a Foley catheter placement for wound management. Note left for Accredidated Registered Nurse Practitioner (ARNP) regarding area who will be in house on rounds tomorrow. Attempted to notify emergency contact with no answer. Message left requesting returned call to facility. Will continue to monitor for any change in status.
b) E-signed by ARNP on 2/15/24 at 3:22 PM notified by nursing this morning of newly discovered wound to resident's coccyx. On assessment she has a decubitus ulcer, stage 3 to intergluteal cleft. Gauze packing present with gauze covering dressing. Wound with mild serosanguinous drainage. Second open more superficial wound to about 4:00. Peri wound with redness to deep purple discoloration. Wound is painful to resident with dressing change. Orders left in facility for dressing changes. Resident is incontinent of urine, order given for Foley catheter for wound care. Consult placed for physician for wound care. She is planning to see resident tomorrow morning. Date wound was identified 2/15/24 on her coccyx, stage 3, measured at 10.17 cm x 6.94cm, 3.08cm x 1.76cm with moderate amount of serosanguinous drainage, no odor. Orders left in facility for: wet to dry dressing pack with gauze soaked in Dakins (clean infected wounds) solution. Cover with boarder Mepilex (absorbent foam dressing). Change BID. Skin prep to peri wound. Insert

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Foley catheter for wound care, liquicel (liquid protein) twice a day (BID), consult dietician for nutritional support for wound healing, consult Doctor of Osteopathic medicine (DO) for continuing wound care, complete blood count (CBC) with differential, sedimentation rate (look for inflammation in body), basic metabolic panel (BMP) today, air mattress, and frequent repositioning of patient.
c) On 2/16/24 11:07 AM resident seen by DO today for an assessment of her coccyx wound, wound debrided during today's visit. Wound measured 14cm x 13cm x 3.5cm, moderate serosanguinous drainage noted, noted redness to surrounding skin area, resident tolerated procedure well, no complaints of pain, treatment orders in place, family updated and plan of care ongoing.

An Initial Wound Evaluation and Management Summary dated 2/16/24 documented by DO. The following was documented: resident present with a wound on her coccyx. At the request of the referring provider a thorough wound care assessment and evaluation performed today. Focused wound exam (site 1): stage 4 pressure wound that measured 14 cm x 13 x 3.5cm with a surface area of 182cm. There was moderate serosanguinous drainage with 70% thick adherent devitalized necrotic tissue, 20% slough and 10% other viable tissue (muscle, bone). Site 1 Surgical Excisional Debridement Procedure: to remove necrotic tissue. The wound cleansed with normal saline and anesthesia achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups used to surgically excise 36.4cm of devitalized tissue and necrotic periosteum and bone along with slough and biofilm were removed at a depth of 4 cm and

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healthy bleeding tissue observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 90 percent to 70 percent. Hemostasis achieved and a clean dressing applied.

Observation on 2/21/24 at 2:45 PM revealed resident had an air mattress on her bed. There was a pair of Prevalon boots in her chair, a black wedge, two chair cushions and a U-shaped chair cushion in her room. Only two pillows noticed in her room, rested on her bed. On 2/22/24 at 1:45 PM resident remained at the hospital.

On 2/21/24 at 4:12 PM Staff K Registered Nurse (RN) called. The number stated the party was unavailable, please try again later and the call ended.

On 2/21/24 at 4:18 PM Staff M LPN stated total body skin assessments are usually completed in the morning or evenings and when there is a new skin area of concern. They do have a wound physician that will come in and assess and complete the treatments if the wounds are chronic or in bad shape. When asked how she completes the skin assessment she stated she usually goes in while they are getting their shower to check everything. She will also let staff know so she can do a skin check during cares, then they will come get her. She did take care of Resident #11 and when she did care for her she spent most of her days in bed. When staff would get her up in her wheelchair she instantly wanted to go to bed. Staff M added the resident was incontinent of urine and bowel. Since she met her she could tell her cognition had decreased due to her brain tumor. At the beginning of her time at the facility, Resident #11 was more active with

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movement but now she does not move at all. When asked how Resident #11 would reposition, Staff M stated she would do little movements but would not roll over on to her side for offloading, staff would do that. When asked if she noticed her offloading she stated she's not sure because she was a bigger lady and would flatten the pillows or anything they put under her to offload. She does not remember seeing positioning wedges or body pillows of any kind in her room. When asked if Resident #11 had skin issues, Staff M stated just on her buttocks, they were putting triad cream on it for a little while. Then they started to discontinue a lot of the treatments because it was too expensive so they either changed to no treatment or to A&D ointment, creams like that. Her bottom had a pinkish tint to it but did not know how long ago it started. Staff M stated she had a regular mattress and that did not make sense to her since she was a bigger woman. The last few times they repositioned her, staff went to pull the sheets from under her and they found a big wound on her buttock that required cleansing and packing. She indicated this was found on the morning of February 15th. She believed staff had known about it for a day or two before that. Staff M was asked if she felt the facility did everything they could to prevent this wound from developing she stated she was unsure but felt they could have done more. When asked what she would have done differently she stated for a woman her size she would get overlooked. Staff would not want to do cares on the bigger residents because they were harder to do. Plus, when they run short on the overnight shifts it's harder for staff to do cares like they would like to do. Once the wound was discovered they inserted a Foley catheter, repositioned her more and an air mattress was put in place.

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On 2/21/24 at 4:34 PM Staff B Licensed Practical Nurse (LPN) stated the Director of Nursing (DON) makes a list on paper of what skin assessments she wants checked, then leaves it at the nurse's station for the nurses to complete. When asked how those assessments are completed she stated the nurse goes in and checks the skin, then will go to the computer and chart in the Electronic Health Record (EHR) this includes any new areas. She likes to do them while the residents are in bed before they get dressed. Staff B stated she was recently educated to look at every skin area, separate the buttocks and lift folds to see if there are any wounds. When asked why this education was provided she stated they recently had a large woman that had a wound but all she knew she had was an area where they were putting cream on it. She admitted before she was not separating the skin to look for wounds, she would just turn the resident side to side, not open up the buttocks to see if there were wounds. She never saw the wound that was developed but was told it was between her buttocks and since she was obese you would have to separate the butt cheeks. Other staff members told they would have to lift the excess skin to see the wound. Staff B stated nobody noticed that wound, not even the DON when she went in to her room, no one noticed it because she was a bigger lady. Staff B stated when she would work on Resident #11's hall, she was always in bed, was not up in her wheelchair but when they tried to get her up she would cry to go back to bed. She could not recall what kind of bed the resident had and indicated she was not sure if the CNAs were turning her or not. Staff B stated Resident #11 was incontinent of urine and bowel. When asked if the resident was ever in bed

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offloading, she acknowledged when she would go in to do the cream treatment she never saw pillows under her. When asked if she felt the facility could have done more to prevent the pressure ulcer from developing she stated she felt bad that no one noticed it. She felt there was too much to do with what staff they had on the floor working. She felt staff are over worked and under staffed. She added Resident #11 was on the skilled unit and they need more staff on that unit. She felt if they been staffed well, this would not have been an issue but everyone is rushed there.

On 2/21/24 at 4:59 PM Staff C LPN stated skin assessments are completed dependent on what resident the DON tells nurses that need an assessment completed. When asked how they are completed she stated she will go to their rooms to complete the skin assessment while they are in bed. When asked to talk about Resident #11 she stated she liked to spend most of her time in bed, and did not recall if she got out of bed. When the resident was first admitted she was working with therapy and got her up maybe one time. She would get up to shower maybe twice. Staff C was asked if staff assisted Resident #11 with repositioning and she stated the resident could not do that herself, staff would have to do it but was unsure how they repositioned her. When asked what she meant she stated that floor is busy but when she would go in there she would see her on her side, not sure for how long those. When staff are busy they can't pay attention to everything. Staff C unsure what kind of bed the resident had because she was always in it. She recalled Resident #11 had superficial areas on her bilateral buttocks that they were applying creams to. Staff C added only nurses could apply

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those creams and would be signed out on the TAR every shift. When asked if Resident #11 had any open wound, she stated they were not open just superficial, and two areas. She did not see anything else, she couldn't see anything else. When asked what she meant by that she stated unless you were looking for something or aware of it, you would need to separate her butt cheeks. She indicated Resident #11 was a big lady and when she would lie down the skin lays over itself making it hard to see anything. To see anything, you have to move the area, lift the buttocks with two hands to see the superficial areas.

On 2/21/24 at 6:19 PM Staff L Certified Medication Aide (CMA) stated she never assisted with any personal cares and was unsure what kind of bed she had. When asked if she noticed Resident #11 being repositioned she stated she had not noticed her being repositioned on her sides. She had witnessed some CNAs telling nurses that Resident #11's bottom needed attention but that was it.

On 2/22/24 at 8:14 AM Staff F CNA stated Resident #11 would get out of bed with therapy and with staff. Once she was up she would not want to stay up long because she complained of back pain. She had a regular mattress, no air mattress but did get an air mattress after they found the wound. Resident #11 required staff assistance for positioning because of her left sided weakness. Staff F stated when she would go in to Resident #11's room she would put a pillow under her arm or lower back because she would not roll on her own. It usually took 3-4 staff to do this. When asked if she noticed any skin issues Staff F stated she had one open area by her tailbone but it was not big. Staff F stated she

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was off when the bigger wound was discovered but when she came back to work they told her about it. She indicated the resident was incontinent of bowel and bladder. When the resident first came to the facility she would let staff know when she needed changed but when she started to decline she would not use her call light to be changed so they would just check and change her.

On 2/22/24 at 8:40 AM the ARNP stated she was not aware that Resident #11 had wounds prior to the wound found on her buttock. When asked on the day she went to the facility to assess the wound what kind of mattress Resident #11 was laying on she indicated a regular mattress. She added after she completed her assessment she did order an air mattress for the resident as well as an order to insert a Foley catheter. The ARNP indicated the wound was located on Resident #11's coccyx and could be seen if you separated her butt cheeks. If they were not separated you could see there was something there but could not see the entire wound that way. She was unsure how long it took for the wound to develop but added Resident #11 has poor nutrition, would refuse cares at times which included repositioning but she could not speak for what took place the week prior to finding it. She added since she was incontinent of urine a catheter was inserted to promote wound cleaning. When asked if she felt the facility did what they could to prevent this wound from developing she indicated she was not sure what they were doing to prevent it from happening since she was admitted.

On 2/22/24 on 9:21 AM the DO stated when she went to the facility February 16th that was the first time she saw Resident #11 and the first time she

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was aware of any skin issues. She was asked if you could see the wound without separating her butt cheeks, she stated it was a large wound and once the dressing was removed you could see it. The wound was not small and it's not hidden. She has had patients of that size with the same wound and would need to separate the fatty tissue to see it. She added this wound did not just happen, it was past that point because it was advanced. She added she was unsure when it started. When she went to see the resident on February 16th, she was lying on her side, uncovered and staff had her butt cheeks separated. With the size of the wound she believed you could see it if you went in to do cares. Once she assessed the wound she debrided it, she was concerned about Resident #11 being in pain but she slept through it. When asked what stage the wound was she stated stage IV because she could probe bone during the treatment. Her assessment note would be in the resident's medical record. When asked if this wound was avoidable or unavoidable she indicated she does not use those terms. She has seen a lot of residents in situations where they are prone to the development of wounds or susceptible to pressure ulcers because they are bed bound, hardly out bed, does not move themselves, or needs to be repositioned. The resident was immobile, had chronic medical conditions and at high risk of pressure wounds so it's not black and white when it comes to avoidable and unavoidable.

On 2/22/24 at 9:34 AM and 2/26/24 at 10:27 AM attempts were made to speak with Staff I Unit Manager. At the conclusion of the survey, no return call received.

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On 2/22/24 at 11:31 AM the DON stated total body skin assessments are completed upon admission and once a week. When asked how they are completed she stated whenever they have time to do them, they are to do a head to toe to look at all the skin either in the shower or before getting out of bed. The DON indicated when Resident #11 was admitted the assessment documented redness to her buttock but unsure what interventions were put in place and she would have to look. When asked about offloading she stated Resident #11 would be repositioned frequently, with pillows to keep pressure at a minimum. They would attempt to get her up in the wheelchair throughout the day but did not do well with that. She believed they would attempted to get her up for an hour a day. She had a standard pressure relieving mattress prior to getting the air mattress. Resident #11 weighed 318 pounds and felt the pressure relieving mattress was sufficient for her because it was wider than a standard mattress. When asked where the skin assessments were from 12/7/23-12/22/23 she obtained daily skin assessment sheets from her office. She was able to find assessments on 12/8/23: groin was red with treatment in place and 12/22/23: no new skin issues noted. The DON shown the TARs that lacked documentation of the Z-guard being signed out as completed and she stated awesome. When asked who completes those treatments, she stated the nurses do. When asked about the new wound she stated once her butt cheeks were separated you could see it was there: sacrum, coccyx, buttocks but was not sure on exact measurements. There was redness like shearing on her butt cheeks that were visible during cares and baths. When asked if the wound was visible during cares she stated not the entire area,

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would, had to lift the skin up but you could see there was excoriated areas. When asked what her expectations were while the nurses completed skin assessments she stated staff should be lifting the breasts and folds, looking between toes and spreading the resident's butt cheeks to look for any skin issues. When she spoke with nurses about what had happened they acknowledged they were not separating the resident's butt cheeks to look for any skin breakdown. She educated nurses on how to complete skin assessments, did a facility skin sweep on all residents. Education also went out to the CNAs and CMA's. They put an air mattress on her bed, inserted a Foley catheter, labs, started supplements as well. They will do random skin checks 4 times a week with the wound nurse. The DO came to the facility to assess the wound. When asked if she felt the facility did enough to prevent this wound from developing she acknowledged that if staff would have opened Resident #11's butt cheeks during their assessment they would found it sooner. However, she is questioning if it's a Kennedy ulcer since she will be returning to the facility on hospice, so that makes her wonder if that is what is was.

On 2/22/24 at 6:21 PM Staff J CNA stated Resident #11 liked to stay in bed. When they would get her up in her chair, she would only be up for 5 minutes because she would complain of pain and want to go back to bed. In the beginning Resident #11 would let them know when she was wet or needed to be changed. After she started to decline, she would be checked and changed by staff. One night they tried to put a pillow under her she saw the sore on her bottom. She gets cream but this was past that stage, she needed a

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dressing. On Wednesday the 14th she told the nurse and the nurse told her she would look at it later. The nurse told her to get the cream but she refused to do it because it needed more than cream. On the 14th, Staff J stated they were doing cares on her and noticed blood on her brief, cream was not going to help bleeding she needed a dressing. She told the nurse they were not going to dress her, they needed to come look at it. Staff J refused to do anything until the nurse came in. Staff I came in and looked at it. The nurse on duty that night was Staff K RN. When asked if she could see the wound if she was just looking at her buttock, she stated you had to separate her butt cheeks to see it. When she did that she saw the sore and blood. They were completing cares and Resident #11 kept saying ow, ow and that's when they saw the wound. She stated everyone had to have known about it, "how could you not."

The Pressure Injury Prevention and Management Policy with an implemented date of 10/24/2022 documented the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The policy defined pressure ulcer/injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device.
Policy Explanation and Compliance Guidelines:
1. There are multiple terms used to describe this type of skin damage, including pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. For purposes of this policy, pressure injury, as the current standard

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terminology, will be used.
2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.
3. Assessment of Pressure Injury Risk
a. Licensed nurses will conduct a pressure injury risk assessment, using the Braden Risk Assessment Score, on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly.
b. The tool will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of risk factors include, but are not limited to:
i. Impaired/decreased mobility and decreased functional ability:
ii. Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
iii. Drugs such as steroids that may affect healing;
iv. Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency;
v. Resident refusal of some aspects of care and treatment;
vi. Cognitive impairment;
vii. Exposure of skin to urinary and fecal incontinence;
viii. Under nutrition, malnutrition, and hydration deficits; and
ix. The presence of a previously healed pressure injury.
c. Licensed nurses will conduct a full body skin assessment on all residents upon

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admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record.
d. Assessments of pressure injuries will be performed by a licensed nurse, and documented on the Weekly Wound Tracking UDA/Skin Wound Note The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS.
e. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task.
f. Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury assessment will be provided as needed.
4. Interventions for Prevention and to Promote Healing
a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.
b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).
c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to:
i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.);
ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination;
iii. Provide appropriate, pressure-redistributing,

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support surfaces;
iv. Provide non-irritating surfaces; and
v. Maintain or improve nutrition and hydration status, where feasible.
d. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present.
i. Pressure injuries will be differentiated from non-pressure injuries, such as arterial, venous, diabetic, moisture or incontinence related skin damage.
ii. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge and surrounding tissue characteristics.
e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care.
f. Interventions will be documented in the care plan and communicated to all relevant staff.
g. Compliance with interventions will be documented in the weekly summary charting.
5. Monitoring
a. The RN Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record.
b. The attending physician will be notified of:
i. The presence of a new pressure injury upon identification.
ii. The progression towards healing, or lack of healing, of any pressure injuries weekly.
iii. Any complications (such as infection, development of a sinus tract, etc.) as needed.
c. A Focused Incident Review will be performed on each pressure injury that develops in the

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facility. Findings will be reported in the monthly QAA Committee Meeting.
d. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QA Committee Schedule, and as needed when actual or potential problems are identified.
6. Modifications of Interventions
a. Any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner.
b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include:
i. Changes in resident's degree of risk for developing a pressure injury.
ii. New onset or recurrent pressure injury development.
iii. Lack of progression towards healing.
iv. Resident non-compliance.
v. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.

The facility's Skin Assessment with an implemented dated of 2/14/22 documented it is the facility's policy to perform a full body skin assessment as part of their systematic approach to pressure injury preventions and management. This policy includes the following procedural guidelines in performing the full body skin assessment.
Policy Explanation and Compliance Guidelines:
1.A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of

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condition or after any newly identified pressure injury.
2. Procedure:
a. Wash hands.
b. Explain the procedure to the resident.
c. Provide privacy and adequate lighting.
d. Put on gloves.
e. Begin head to toe, thoroughly examining the resident's skin for conditions. Pay close attention to pressure points, bony prominence, and underneath medical devices.
f. Remove any special garments or devices, if not contraindicated or ordered to remain in place.
g. Remove any dressings, using clean technique, unless contraindicated or ordered to remain in place, and note findings.
h. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions.
i. Dispose of contaminated items safely.
j. Remove gloves and perform hand hygiene prior to leaving room.
3. Consider the general status of the resident's skin.
a. Color.
b. Temperature.
c. Moisture status.
d. Sensory perception.
e. Skin texture/turgor.
f. Perfusion.
4. Considerations for a resident with darkly pigmented skin:
a. It is not always possible to identify redness on darkly pigmented skin.
b. Indicators of early pressure damage:
i. Localized heat
ii. Edema
iii. Bogginess
iv. Induration

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F 686	Continued From page 42 v. Temperature differences of surrounding skin vi. Skin discoloration 5. Considerations for a bariatric resident: a. Perform assessment with at least one other staff member to assist with mobility and positioning of body parts. b. Approach resident in a manner that promotes dignity and respect. c. Thoroughly inspect each surface of a skin fold. d. Consider moisture and weight exerted by opposing skin and/or body parts (i.e. abdominal pannus) when determining pressure versus moisture related etiology. Pressure injuries may result from tissue pressure of high concentration of adipose tissue, and may be in areas other than bony prominence's. 6. Differentiating the extent of redness a. Blanchable erythema (redness) loses its redness when a finger is pressed on the erythema for 3 seconds and released. Blanching is assessed following the removal of the finger. b. Non-blanchable erythema (redness) persists when touched. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interviews and facility policy review the facility failed to ensure 1 of 3 residents (Resident #5) was assessed for an elopement risk after he left the building on 2/13/24. The facility reported a census of 110 residents.

Findings include:

The admission Minimum Data Set (MDS) assessment tool with a reference date of 2/13/24 documented Resident #5 had a Brief Interview of Mental Status (BIMS) score of 4. A BIMS score of 4 suggested severe cognitive impairment. The MDS documented he had an admission date of 2/9/24. Resident #5 exhibited wandering behavior daily during the review period. He needed partial assistance from another person for indoor mobility, had impairment to both of lower extremities and utilized a walker. Resident #5 required supervision or touching assistance to walk 50 feet with two turns. The MDS documented he had the following diagnoses: metabolic encephalopathy, diabetes mellitus, dementia, anxiety, and chronic obstructive pulmonary disease.

The Care Plan focus area with an initiation date of 2/13/24 documented Resident #5 was alert and

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oriented to person due to his diagnoses of dementia/encephalopathy. His mood varies from ok to angry, he had behavioral expressions of resistance with cares and elopement issues. The care plan lacked interventions for staff to utilize.

An Elopement Assessment dated 2/9/24 at 3:45 PM, documented he did not have an elopement risk. An Elopement Assessment dated 2/16/24 at 10:06 AM, documented he had an elopement risk.

The Treatment Administration Record (TAR) for February 2024 contained the following order: check wander guard for placement and functioning every shift, for wandering, with a start date of 2/9/24.

The Progress Notes documented the following:
a) On 2/9/24 at 4:27 PM the resident admitted around 3:00 PM. Resident #5's gait is not steady and he continued to ambulate without assistance.
b) On 2/11/24 at 8:17 AM the resident very anxious and restless. He continued to pace the halls, setting off the door alarms, seeking to exit, stating he wanted to go home. Resident #5's significant other called by staff three times to talk to him but he continued to attempt to elope, went in to other resident's rooms. Staff redirected, toileted, offered drinks and something to eat but these interventions did not help for a long time as he began to pace the halls again.
c) On 2/12/24 at 8:03 PM the resident continues to pace the hall this shift, setting off the door alarms, going in to other resident's rooms and going through their stuff. Staff redirected each time with difficulty as he would attempt to hit other residents and staff. He would take his clothes off and come out in the hallway with only his

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depends on. Resident #5 stated he wants to go home, highly exit seeking behavior noted. His significant other called by staff three times to talk to him, to calm him down but that did not work for too long. Resident finally laid down in his bed and went to this this morning.
d) On 2/13/24 at 7:17 AM the resident on follow up for behaviors and wandering. Resident pleasant this shift but very confused. Easily redirected, but did not sleep this shift. He did attempt to open the door at the end of the hall by the old activity room and set off the alarm while looking for the stairs. Resident reassured there were no stairs in the building and successfully redirected him.
e) On 2/13/24 at 9:00 AM staff saw Resident #5 in the parking lot and brought him back into the facility. He may have gone outside through the hall's exit door. Exit door alarming. When he eloped, staff working on his hall were busy assisting other residents in the rooms.
f) On 2/13/24 at 12:53 PM nurse notified that resident had exited outdoors this morning at approximately 7:30 AM this morning. The door and wander guard alarms both sounded. Staff members responded to alarms appropriately and began to search. Two staff members went outside of the door that had alarmed while other staff members searched rooms inside. While outside, a unit manager had arrived to work, observed him and brought him immediately inside. He denied pain and no injuries noted after an assessment was completed. Resident #5 placed on one to one supervision with a Certified Nursing Assistant (CNA). While interviewing staff regarding the incident, the CNA performing one to one supervision stated the resident observed staff coming in the employee entrance and attempted to go out that door. Resident

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immediately redirected and is now with activities for one to one supervision.
g) On 2/13/24 at 10:00 PM the resident had one on one care this evening. He continued to pace the halls, going to other units with his staff member. He went to the dining room for supper. Resident #5 attempted to reach for exit door but timely redirected away from the door. No elopements this shift.

Observation on 2/15/24 at 11:53 AM revealed an exit door on the resident's hall. The door had an egress door with the follow wordage on the door: push the door for 15 seconds as the alarm sounds and opens. Once the door is opened, the sideway led to a small parking lot and residential area. At 11:55 AM resident sat in his recliner in his room, looking out the window. Resident had a wander guard on his left wrist.

On 2/15/24 at 11:55 AM Resident #5 denied ever leaving the facility or walking outside to the parking lot.

On 2/16/24 at 9:35 AM the DON stated since Resident #5 had been admitted he was pretty restless and had behaviors that included aggression, agitation and he eloped. He would wander in and out of other resident's rooms and had door seeking behavior since he admitted. Staff to redirect these behaviors and that appeared to help. They also put a wander guard on him, kept an eye on him and had him up at the nurse's station a lot. She was not in the building the morning he eloped but arrived shortly after. She indicated he did not elope because her staff followed the facility's process, they put him on one to one, staff were educated. She indicated staff immediately went outside when they heard

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the alarms sounding, did a head count and Staff G had him and brought him back inside. When asked what her definition of elopement was, she stated if staff did not follow their process, if the alarms sounded and they did not go meet him, if a head count was not completed, and did not look for him. She again stated Staff G saw him and grabbed him, he had just come out of the door. When asked what staff had eyes on him the whole time she again stated Staff G did when he came out the door. When asked if staff was physically with him from the time he left his room until he went outside, she stated Staff G got him, staff did not follow him out the door. At the time he left the building staff were closely observing him but afterwards he was on one to one supervision. The DON was informed an elopement assessment had not been completed after he left the building on 2/13/24. When asked if one should have been completed she stated Staff G indicated she was asked the same question, then indicated there should have been one completed.

During a follow-up interview on 2/27/24 at 2:13 PM the DON acknowledged she completed the elopement assessment after she initially spoke to the surveyor on 2/16/24. She stated its not completed by a score, it's either the resident is at risk or not at risk. She indicated the questions were the same as when it was first completed on admission and the answers were the same. She added the outcome of the assessment would not have changed based on the events but she did it anyway and his risk level did not change.

The facility's Elopements and Wandering Residents Policy with a revised date of 8/12/2022 indicated the facility ensures that residents who

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F 689	Continued From page 48 exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation monitoring for effectiveness and modifying interventions when necessary. Monitoring and management residents at risk for elopement or unsafe wandering: a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		

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F 842	Continued From page 49 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility policy review the facility failed to ensure Resident #6, #7, and #8 medical record contained bath records and Resident #11 medical record contained completed skin assessments. The facility reported a census of 110 residents.

Findings include:

1) According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 12/6/23 Resident #6 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented Resident #6 was dependent on staff for showering/bathing. The MDS documented the following diagnoses: heart failure, renal failure, diabetes mellitus, depression, chronic pain and COVID-19.

The Care Plan focus area with an initiation date of 3/2/22 documented Resident #6 had activities of daily living (ADL) self-care performance deficit related to weakness, fatigue, and impairment balance. The care plan documented staff were to provide her with a sponge bath when a full bath or shower cannot be tolerated.

Record review of Resident #6's Electronic Health

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	165448	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP DRUMM RETIREMENT CENTER	5837 WINWOOD DRIVE JOHNSTON, IA 50131

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Record (EHR) revealed the bathing record for January 2024 and February 2024 lacked documentation of baths being completed two times a week.

2) The quarterly MDS assessment tool with a reference date of 12/10/23 documented Resident #7 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented Resident #7 was dependent on staff for showering/bathing. The MDS documented the following diagnoses for the resident: cancer, coronary artery disease, neurogenic bladder, depression, atrial fibrillation, and morbid obesity.

The Care Plan focus area with an initiation date of 5/11/2021 documented Resident #7 had ADL self-care performance deficit related to impaired balance, limited mobility, pain, morbid obesity history of left tibia/fibula fracture and non-weight bearing. The care plan documented staff were to provide her with a sponge bath with a full bath or shower cannot be tolerated.

Record review of Resident #7's EHR revealed the bathing record for January 2024 and February 2024 lacked documentation of baths being completed two times a week.

3) The admission MDS assessment tool with a reference date of 2/2/24 documented Resident #8 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented he was dependent on staff for showering/bathing. The MDS documented the following diagnoses: atrial fibrillation, heart failure, renal failure, benign prostatic hyperplasia, pneumonia, and respiratory failure.

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The Care Plan focus area with an initiation date of 2/6/24 documented Resident #8 had ADL self-care performance deficit related to morbid obesity, fatigue, impaired balance, limited mobility, shortness of breath and recovering from bacterial pneumonia. The care plan documented he was dependent on staff to provide a bath as necessary.

Record review of Resident #8's EHR revealed the bathing record for January 2024 and February 2024 lacked documentation of baths being completed two times a week.

On 2/21/24 at 10:51 AM the facility provided emailed scanned bath audits the staff filled out when the baths are complete and return to the Director of Nursing (DON). These bath audit sheets are not part of the resident's medical record for Resident #6, #7 and #8.

On 2/15/24 at 1:35 PM Staff F Certified Nursing Assistant (CNA) stated when they complete resident's baths they chart in their EHR and on the bath sheets the DON prints out for them. Once the CNAs complete the sheets, the nurse will sign it and give it to the DON.

On 2/16/24 at 9:09 AM Staff H CNA stated after a resident receives a bath, they are to chart it in the shower book and in the computer as well.

4) The admission MDS assessment tool with a reference date of 12/11/23 documented Resident #11 had a BIMS score of 9. A BIMS score of 9 suggested she had mild cognitive impairment. An admission date was documented at 12/7/2023. Resident #11 did not exhibit rejection of care during the 7-day review period. The MDS

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indicated Resident #11 at risk for the development of pressure ulcers/injuries and had no unhealed pressure ulcers/injuries. Resident #11 had moisture associated skin damage (MASD), had a pressure reducing device for her chair and bed, was not on a turning/repositioning program, did not utilize nutrition or hydration interventions to manage skin problems and had ointments/medication other than to her feet. The MDS documented her weight in pounds 327 and 64 inches tall. The following diagnoses to include: stroke, cancer, diabetes mellitus, hemiplegia, seizure disorder, anxiety, morbid obesity, and body mass index (BMI) 50.0-59.9.

The discharge-return anticipated MDS assessment tool with a reference date of 2/16/24 documented Resident #11 had severely impaired cognitive skills for daily decision making. She did not exhibit rejection of care during the 7-day review period. Resident dependent on staff for toileting hygiene, showering, dressing, chair/bed to chair transfer. The MDS documented she had an unhealed stage 4 pressure ulcer/injury that was not present upon admission.

The baseline care plan for Resident #11 dated 12/7/2023 documented the following skin integrity issues: slight redness to groin, abdominal folds, and groin. Her bilateral lower extremities and feet dry and scaly.

Review of Resident #11 EHR revealed it lacked skin assessments from 12/7/23-12/22/23.

On 2/22/24 at 11:31 AM informed the DON skin assessments from 12/7/23-12/22/23 not documented in the EHR. She went to her desk, obtained paper daily skin assessments and was

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F 842	Continued From page 54 able to find assessments completed on 12/8/23 and 12/22/23. These documents were not part of her medical file. During a follow up interview with the DON on 2/27/24 at 2:13 PM she stated staff can chart when baths are completed in the EHR or paper sheets. The CNAS have the option to chart in their EHR but she also does bath audits with skin assessments. She has bath audits because staff forget to chart in EHR so she can audit the papers if they did not chart in EHR. The facility's Charting and Documentation with a revision date of July 2017 documented all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interviews and facility policy review the facility failed to follow infection control practices while completing incontinent cares for 1 of 3 residents (Resident #14). The facility reported a census of 110 residents.

Findings include:

The quarterly Minimum Data Set (MDS) with a reference date of 12/15/23 documented Resident #14 had a Brief Interview of Mental Status (BIMS) score of 8. A BIMS score of 8 suggested mild cognitive impairment. The MDS documented the resident always incontinent of urine and bowel. The MDS documented the following diagnoses for Resident #14: dementia, coronary artery disease, depression, and COVID-19.

The Care Plan focus area with an initiation date of 3/20/2020 documented she had activities of daily living (ADL) self care performance deficit related to dementia, impaired balance, limited mobility and weakness. The care plan

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documented she required assistance from staff with personal hygiene care. Staff directed to ask Resident #14 routinely and as needed if she needs to use the restroom to prevent soiling herself. Staff are to assist her with incontinent cares as needed.

On 2/23/24 at 1:00 PM Staff N Certified Nursing Assistant (CNA) had performed incontinent cares so Staff B Licensed Practical Nurse (LPN) could apply cream to Resident #14 buttocks. With gloved hands Staff N removed the resident's brief and noted the resident incontinent of bowel. With the same gloved hands Staff N received adult wipes and moved a trash can closer to her. Staff N then completed incontinent cares by pulling adult wipes from the packet with her right hand, then cleaning the resident's peri-area in an upward motion. Staff N continued with the same gloved right hand to pull adult wipes from the same packet and cleanse the resident in an upward motion two more times. Staff N removed her gloves and rubbed her hands together in a manner one would do if they had hand sanitizer. Observation of the bedside where she stood next to revealed no hand sanitizer. She donned a new pair of gloves to continue with incontinent cares by obtaining new wipes with her right hand after cleansing the resident with that same hand. Staff N and Staff B realized they did not have a new bed pad, Staff B stepped out to get a bed pad. Staff N removed her gloves, rubbed her hands together without the presence of hand sanitizer and donned a new pair of gloves. Once Staff B returned she brought in hand sanitizer and cares completed. Staff N failed to change her gloves between tasks, perform hand hygiene and perform incontinent cares while using infection control practices.

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On 2/27/24 at 2:13 PM the Director of Nursing (DON) stated staff should not be wiping front to back when completing incontinent cares on residents. Staff are to change their gloves between dirty and clean tasks, and wash them or use hand sanitizer between change of gloves. Staff N should have obtained the adult wipes from the package with her left hand if she was wiping with her right hand or she could have taken wipes out of the package before she started and placed them on a clean barrier. She should not have used the same hand to cleanse and remove wipes from the packet.

The facility's Perineal Care policy with a revision date of February 2018 documented the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. For a female resident: separate labia and wash area downward from front to back. Remove gloves, wash and dry hands thoroughly.

The facility's Hand Hygiene policy with a revision date of 5/9/23 documented all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility.
Policy Explanation and Compliance Guidelines:
1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.
2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.
3. Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in

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most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.
4. Hand hygiene technique when using an alcohol-based hand rub:
a. Apply to palm of one hand the amount of product recommended by the manufacturer.
b. Rub hands together, covering all surfaces of hands and fingers until hands feel dry.
c. This should take about 20 seconds.
5. Hand hygiene technique when using soap and water:
a. Wet hands with water. Avoid using hot water to prevent drying of skin.
b. Apply to hands the amount of soap recommended by the manufacturer.
c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers.
d. Rinse hands with water.
e. Dry thoroughly with a single-use towel.
f. Use clean towel to turn off the faucet.
6. Additional considerations:
a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.
b. Bar soap is approved for a resident's personal use only. Keep bar soap clean and dry in protective containers (i.e. plastic case or bag).
c. Liquid soap reservoirs must be discarded when empty. If refillable, dispensers must be emptied and cleaned, rinsed and dried according to manufacturer instructions.
d. Use lotions and creams to prevent and decrease skin dryness.

Plan of Correction
Bishop Drumm Retirement Center

Provider Number: 165448
Survey Date: 02/27/2024
Allegation of Compliance: 3/20/2024

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and federal law.

Please accept this plan as the organization's credible allegation of compliance.

F 656 Develop/Implement Comprehensive Care Plans

It is the practice of this facility to implement a comprehensive care plan for residents..

a. Resident #5 no longer resides in the facility.
b. The facility has determined that all residents have the potential to be affected.
c. All interdisciplinary care plan team members responsible for writing care plans were re-educated on the facility's policy and procedure for developing *Comprehensive Care Plans.*
d. Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s). All care plans will be updated as indicated.

   The Director of Nursing Services (DNS), or designee, will complete random weekly audits of care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents.

   Audit records will be reviewed by the QAPI Committee monthly for 3 months, or longer as determined by the committee.

   Corrective action completion date: 3/20/2024

F 658 Services Provided Meet Professional Standards

It is the practice of this facility to provide care and treatment to residents that meets professional standards..

a. Residents # 4 and #11 no longer reside in the facility.
b. The facility has determined that all residents have the potential to be affected.
c. On 2/22/2024, the Director of Nursing initiated inservice education for all licensed staff regarding the provision and documentation of physician ordered treatments.
d. The Director of Nursing or designee will monitor the provision of services ordered and provided for residents for ten (10) records per week for one (1) month then five (5) records every two (2) weeks for two (2) months. Discrepancies will be promptly reported to the Administrator.

Audit records will be reviewed by the QAPI committee monthly for 3 months, or longer as determined by the committee.

Corrective action completion date: 3/20/2024

F 686 Treatment/Services to Prevent/Heal Pressure Ulcers

It is the practice of this facility to provide skin assessments per policy and provide treatments per physician's orders to prevent the development and worsening of a pressure ulcer.

a. Resident #11 no longer resides in the facility.
b. The Director of Nursing and designee(s) conducted skin assessments on all residents, and performed an audit of all pressure relieving devices and support surfaces to ensure proper use.
c. The Director of Nursing or designee provided education to all licensed nurses on the facility policies and procedures related to skin/wound care, as well as appropriate wound treatment measures. The Director of Nursing or designee educated all nurse aides on preventative skin care.
d. The Director of Nursing or designee will conduct treatment record/documentation audits on 5 residents weekly for one month, the 5 residents every two weeks for two months to ensure accurate and complete documentation of skin related treatments and preventative measures.

   The Director of Nursing or designee will audit 3 residents each week for one month then 3 residents every two weeks for two months: observing treatments, preventative skin care, weekly skin assessments.

   The results of audits will be shared with and monitored by the QAPI committee for three months, or longer as determined by the committee.

   Corrective action completion date: 3/12/2024

F 689 Free of Accident Hazards/Supervision/Devices

It is the practice of this facility to ensure that residents are appropriately assessed after an elopement.

a. Resident #5 no longer resides at the facility.
b. The facility determined that all residents at risk for elopement have the potential to be affected.
c. The Director of Nursing or designee provided education to licensed nurses regarding the facility elopement policy and facility protocol for assessing residents after an elopement.
d. The Director of Nursing of designee will conduct random weekly audits for 6 weeks of residents at risk for elopement to ensure appropriate assessments documented.

   The results of audits will be shared with the QAPI Committee for 3 months, or longer as determined by the committee.

Corrective action completion date: 3/20/2024

F 842 Resident Records

It is the practice of this facility to ensure that bath and skin assessment records are documented in the resident record.

a. Bath records for residents #6, #7, #8, and skin assessment record for resident #11 were updated on 2/27/24.
b. The facility determined that all residents have the potential to be affected.
c. The Director of Nursing or designee provided education to nursing staff regarding facility documentation practices.
d. The Director of Nursing or designee will conduct random weekly audits of 10 resident records per week for one month, then 10 resident records every two weeks for two months to ensure documentation of baths and skin assessments are recorded in the resident record.

   The results of audits will be shared with the QAPI Committee monthly for three months, or longer as determined by the committee.

   Corrective action completion date: 3/20/2024

F 880 Infection Prevention and Control

It is the practice of the facility to follow appropriate infection prevention practices while providing incontinent care for residents.

a. The facility has determined that all residents have the potential to be affected.
b. All direct care staff were provided education by the Director of Nursing or designee regarding appropriate incontinent care practices.
c. The Director of Nursing, or designee, will complete random Validation Checklists of direct care staff regarding incontinent cares. To ensure staff are performing the procedure in accordance with our facility's policy, random monitoring will occur each week for 4 weeks, then monthly for 2 months.

   Audit results will be reviewed by the QAPI committee monthly for three (3) months, or longer as determined by the committee.

   Corrective action completion date: 3/20/2024