STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 09/27/2022

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HILLCREST HEALTH CARE CENTER	2121 AVENUE L HAWARDEN, IA 51023

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F 000	INITIAL COMMENTS	F 000		
x	Correction date 10/27/2022			
DC	An investigation of complaints #102977-C, #104053-C, #105054-C, #105147-C, #105153-C, #106821-C, and self reports #104933-M, #106557-I, and #106557-I completed September 6, 2022 - September 27, 2022 resulted in the following deficiencies. Complaint #102977-C, was substantiated. Complaint #104053-C, was substantiated. Complaint #105054-C, was substantiated. Complaint #105147-C, was substantiated. Complaint #105153-C, was substantiated. Self report #106557-I, was substantiated. Complaint #106821-C, was not substantiated. Self report #107376-I was substantiated. Self report #104933-M will come at a later date under seperate cover.			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		10/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/14/2022

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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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, and facility policy and procedures the facility failed to promptly report a resident's fall and skin concern to the or family/resident representative and the	F 580		

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F 580	Continued From page 2 resident physician for 1 of 3 residents reviewed, (Resident #4) The facility identified a census of 47 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) with an assessment reference date 1/4/22, documented Resident #4 with diagnosis for which included hypertension, Alzheimer's Disease, non-Alzheimer Dementia, anxiety, depression, restlessness, agitation and history of falling. The MDS documented the Resident with a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe decision making abilities, with inattention continuously present and does fluctuate. The MDS also documented the resident required supervision with ambulation in room and in the corridor with set up help from staff. The Care Plan stated resident was at risk for falls as I have impaired memory and safety due to my Alzheimer's disease/Dementia, incontinence, anxiety, the medication I take and I use a walker. Interventions include: *Assist me with my ADLs as needed. *Be sure my call light is within reach and encourage to use it to call for assistance as needed. *I use a walker for ambulation. *Keep walker next to resident in dining room. *Resident will place walker away from bed. *Keep walker next to bed when resident is in it if able. *Staff will remind me to use my walker when ambulating. Review of Progress Notes showed documentation on 2/28/2022 at 7:42 a.m.,	F 580	F580 Resident #4 family and Physician have been updated on all recent changes in resident condition. To continue to protect this resident and all other residents, nursing staff was educated on ensuring all changes of condition are communicated to family/POA and Physician, the policy and procedure for notification of change of condition was reviewed with staff at meeting held on 10/27/22. DNS/designee will audit 24 hour report 3 times weekly for 3 weeks for family and physician notification of change of condition and will educate nursing as needed.	

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F 580	Continued From page 3	F 580		

Environmental/housekeeper summoned nursing staff as resident fell as resident was walking out of her room with walker. Resident was observed laying flat on her right side on the floor with right arm underneath her and left arm on top of her side. Blood noted from underneath head and from underneath her right abdomen area. Walker was a couple of feet outside the room door from where the resident was laying and in the hallway. Walker had clothing on top as well as resident purse. Resident was wearing regular socks only to feet. Floor was clean and dry. Resident was not wearing her glasses and was wearing her nightgown. Resident unable to give accounts of the incident due to her memory loss and confusion. Resident assessed. Vital Signs taken. Blood Pressure was elevated but with follow-up assessments and vital signs, residents blood pressure did decrease to normal level. Neurological assessments started and completed as resident was able due to impairment from Dementia. Range Of Motion assessed with no impairments noted. Legs are of equal length with no external rotation. Shoulders and hips without bruising or injuries and resident was able to move them appropriately as well. Resident assisted up with the help of 3 caregivers and gait belt and assisted into wheelchair. Abrasion/skin tear/hematoma to head cleansed. Skin tears cleansed and applied steri-strips/dressing applied as resident would allow. She did have pain to right hand/finger and would pull away from charge nurse as she was treating these areas. The charge nurse was the only staff member to visual check extent of the skin tear/laceration to right palm/finger. Once treated by charge nurse resident was assisted with dressing, toileting and morning cares. Intervention was to apply gripper socks at night and encourage resident to keep

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F 580	Continued From page 4 them on. Review of the clinical record lacked any documentation that the family/representative or physician had been notified of the incident to the resident on 2/28/22. In an interview on 9/19/22 at 2:45 p.m., the facility Corporate Nurse confirmed the facility staff failed to notify the resident's family/responsible party and primary care physician for the incident and it is the expectation of the nurses to notify family/representative and care provider of the fall and skin injuries. The Notification, Physician or Responsible Party Policy/Procedure dated 8/2007, documented it is the policy of the facility to promptly notify the resident, his/her attending physician, and/or family/responsible party of changes in the residents condition and/or status. 1. The Nurse Supervisor will notify the residents attending physician when: A. the resident is involved in any accident or incident which results in an injury including injuries of unknown source. B. There is a significant change in residents physical, mental, or psychosocial status. C. There is a need to alter the residents treatment significantly. 2. The Nurse Supervision will notify the residents family/responsible party when: A. The resident is involved in any accident or incident which results in an injury including injuries of an unknown source. B. There is a significant change in the residents physical, mental, or psychosocial status. C. There is a need to alter the residents treatment significantly.	F 580		

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview the facility failed to ensure staff provided timely peri-care for 1 of 4 residents during personal cares, (Resident #7). The facility identified a census of 47 residents. Findings include: 1. A Significant Minimum Data Set (MDS) assessment form dated 8/29/22 documented Resident #7 had diagnosis that included anemia, hypertension, arthritis, Alzheimer's disease, non-Alzheimer dementia, anxiety, depression and history of falling. The assessment documented the resident with short and long term memory impairments and severely impaired for decision making abilities, required extensive assistance of 2 staff with toilet use, personal hygiene, transfers and bed mobility and always incontinent of bladder and bowels. A Care Plan addressed the following focus areas has bowel/bladder incontinence related to confusion, impaired mobility, and interventions include: *Assist with toileting and provide peri cares for proper hygiene. *Observe skin with cares. An observation on 9/15/22 at 7:15 a.m., revealed Resident #7 sitting up in wheelchair at dining	F 677	F677 Resident #7 has updated care plan and Kardex to better reflect his needs. Staff was educated on 10/27/22 on rounding and to ensure peri care is given for all residents in a timely manner. Peri care policy was reviewed with nursing and nurse aides. This will help to protect all residents to prevent skin breakdown and improve overall care. DNS/designee will audit rounding daily for 2 weeks by rounding with staff 2 times daily and providing real time education as needed.	10/27/22

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F 677	Continued From page 6 room table with a cup of coffee in front of them. An observation on 9/15/22 at 10:45 a.m., Staff K, certified nursing assistant (CNA) and Staff L, CNA assisted Resident #7 from the wheelchair to the resident bed for incontinent cares. During the transfer the residents blue sweat pants appeared to be soiled with urine. Staff K pulled down Resident #7 sweat pants and commented "Oh my, he has soaked through all of his clothing and the brief is saturated." Staff K stated Resident #7 is a heavy wetter and needs to be changed at least every two hours. In an interview on 9/19/22 at 1:00 p.m., the facility Corporate Nurse, confirmed and verified that the residents needed to be checked and change at least every two hours and it is unacceptable to go longer than two hours.	F 677	F684 Resident 4,5,12 have updated skin assessments. All current residents had updated skin assessments completed on 10/17/22, Nursing was educated on 10/17/22 on skin measurements, skin assessments due weekly, and overall skin policy. DNS/designee will audit skin assessments on all residents weekly x3 weeks for completion and will educate nursing as needed. Resident 4,5,12 have neuro assessments completed for any falls that have occurred in the month of October and have been uploaded into the EMR. All residents with unwitnessed falls are to have complete neuro assessments after every fall. Nursing educated on 10/17/22 on fall policy and that all unwitnessed falls require complete neuro assessments after each fall. Neuro assessment policy also reviewed at meeting on 10/17/22. DNS/designee will review all falls daily for 30 days and ensure that neuro assessments are completed and uploaded after falls into the EMR.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy/procedure the facility failed to assess, document, notify the provider and family and provide skin assessments and complete neurological assessments for three of three	F 684		10/17/22

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F 684	Continued From page 7 residents reviewed after post falls/injuries. (Resident #4, #5, #12). Resident #4 was transferred to the local clinic on 3/1/22, where it was determined that sutures had to be utilized to connect the skin on the residents right hand from a fall that occurred on 2/28/22. The facility reported a census of 47 residents. Findings include: Review of a the facility policy and procedure for change of condition reporting dated 7/2021, instructed: Acute Medical Change- 1. Any sudden or serious change in a residents condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and /or acute care evaluation. The licensed nurse in charge will notify the physician. 2. Licensed nurse will inform the primary physician (alternate physician of Medical Director) of resident status as soon as possible once resident needs have been met and immediacy of nursing care is completed. 3. Licensed nurse will inform family/responsible party of change of condition and document notification. 4. All nursing actions, will be documented in the licensed progress notes as soon as possible after resident needs have been met. Review of the facility policy/procedure for skin and wound management dated 5/2021, instructed: 1. A weekly skin assessment will be completed on all residents and documented in the resident medical record or progress note. 2. Each wound will be measured in centimeters weekly. Measurements, size, and depth,	F 684		

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F 684	Continued From page 8 drainage, odor, color and a short statement on progress (or lack of) will be documented on the Skin Pressure Weekly or Skin Ulcer Non-Pressure Weekly. 3. Treatments ordered by the physician will be used. 5. All treatments involving breaks in the skin required clean technique, unless otherwise ordered by the physician. 1. The Quarterly Minimum Data Set (MDS) assessment dated 1/4/22 identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of 4 for which indicated severe decision making abilities. The MDS identified the resident had diagnosis of hypertension, Alzheimer disease, non-Alzheimer dementia, anxiety, depression and history of falling. Resident had no falls, and no skin injuries. The MDS further documented resident required extensive assistance of two staff for bed mobility, dressing, toilet use and personal hygiene, limited assistance for transfer, and supervision with set up help for ambulation in the room and corridor. The Clinic Note dated 3/1/22 at 1:22 p.m., documented, patient here for evaluation of a fall that occurred yesterday morning around 7:40 a.m. Our office was not notified about this until today. Her wounds were cleaned and Steri-Strips were applied. The injury was not witnessed. Patient has significant Alzheimer's dementia and does not verbalize very well. She denies having pain. No recent fever or chills. No other cold or flu symptoms reported. There is a contusion on the right lateral forehead in the hairline. There is a small skin tear on the left dorsal hand. Other skin tear on the right forearm, right dorsal hand over the fifth metacarpal and along the lateral aspect	F 684		

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F 684	Continued From page 9 of the fifth digit. The dorsal aspect of the hand is swollen. The right foot was swollen over the metatarsals. X-Rays were taken of the right hand and right foot. No obvious fractures were noted. The wounds were cleansed with Shur-Clens Will present lidocaine with epi was used locally approximately 5 cc. The right fifth digit 4 centimeter laceration had 5 stitches placed in a simple fashion. The right dorsal hand 3 centimeter laceration had 3 stitches placed in a simple fashion. Antibiotic ointment with Telfa and 2 inch kling was used for dressing. Assessment: 1. Forehead contusion unwitnessed fall. 2. Multiple skin superficial skin tears with steri-strips. 3. Lacerations 4 centimeters to the right fifth digit and 3 centimeter to the right lateral hand repaired in a single-layer. 8 stitches total. Review of the Fall report dated 2/28/22 at 7:22 a.m., documented Environmental/housekeeper summoned nursing staff as resident fell as she was walking out of her room with walker. Resident was observed laying flat on her right side on the floor with right arm underneath her and left arm on top of her side. Blood noted from underneath head and from underneath her right abdomen area. Walker was a couple of feet outside the room door from where the resident was laying and in the hallway. Walker had clothing on top as well as resident purse. Resident was wearing regular socks only to feet. Floor was clean and dry. Resident was not wearing glasses and was wearing her nightgown. Resident is unable to give account of the incident due to her memory loss and confusion. Injuries observed at time of incident: left hand skin tear. (back)	F 684		

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F 684	Continued From page 10 Notes: Resident noted to have skin tear to right inner wrist on the pinky finger side. Has skin v-shaped skin tear to top of left hand. Laceration to outside of right pinky finger. Laceration to outside palm of right hand. Bruise/hematoma to right forehead/temporal area. Review of the Progress Notes dated 2/28/2022 7:42 a.m., documented the following: Environmental/housekeeper summoned nursing staff as resident fell as she was walking out of her room with walker. Resident was observed laying flat on her right side on the floor with right arm underneath her and left arm on top of her side. Blood noted from underneath head and from underneath her right abdomen area. Walker was a couple of feet outside the room door from where the resident was laying and in the hallway. Walker had clothing on top as well as resident purse. Resident was wearing regular socks only to feet. Floor was clean and dry. Resident was not wearing her glasses and was wearing her nightgown. Resident unable to give accounts of the incident due to her memory loss and confusion. Resident assessed. Vital Signs taken. Blood Pressure (BP) was elevated but with follow-up assessments and vital signs, residents BP did decrease to normal level. Other VSS. Neurological assessments started and completed as resident is able due to impairment from Dementia. Range Of Motion assessed with no impairments noted. Legs are of equal length with no external rotation. Shoulders and hips without bruising or injuries and resident is able to move them appropriately as well. Resident assisted up with the help of 3 caregivers and gait belt and assisted into wheelchair. Abrasion/skin tear/hematoma to head cleansed. Skin tears cleansed and applied steri-strips/dressing applied	F 684		

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F 684	Continued From page 11 as resident would allow. She did have pain to right hand/finger and would pull away from charge nurse as charge nurse was treating these areas. The charge nurse was the only staff member to visual extent of the skin tear/laceration to right palm/finger. Once treated by charge nurse, resident was assisted with dressing, toileting and morning cares. Intervention is to apply gripper socks at night and encourage resident to keep them on. Further review of the progress notes documented the following: On 2/28/2022 at 7:17 p.m., Acetaminophen (medication to treat pain) Tablet, Give 650 mg by mouth every 6 hours as needed for pain, given for pain in her hand. On 2/28/2022 at 11:45 p.m., Acetaminophen Tablet, Give 650 mg by mouth every 6 hours as needed for pain, PRN Administration was: Unknown, Follow-up Pain Scale was: 2 On 3/1/2022 at 4:56 a.m., Resident continues on fall f/u with neuros. VS obtained: 152/69-97.6-52-20-pulse oxygen =95%R on room air. Resident Right hand redressed per writer. Purple bruising noted throughout Right hand. Steri strips applied to 5th digit of Right hand. Steri strips reinforced et applied to laceration on Right hand. Resident PAINAD score: 2. Call light within reach. On 3/1/2022 at 9:15 a.m., Residents right hand and fingers swollen, tender when touched. Resident flinches and hollers out in pain. Hand is bruised. Several lacerations noted on the pinky finger. On 3/1/22 at 9:35 a.m., This nurse called clinic. Appointment set up for 10:00 a.m., to have hand evaluated and possible x-rays. On 3/1/22 at 9:37 a.m., This nurse contacted	F 684		

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F 684	Continued From page 12 residents son. Son was not aware of the fall that occurred on 2/28/22. This nurse advised son of the injuries. Son unable to transport resident to the appointment but would like to be updated on findings. Facility to transport. On 3/1/22 at 3:16 p.m., new orders received from clinic appointment for dressing change daily and to remove sutures in 10 days. On 3/3/22 at 10:06 a.m., Appointment made for fall follow-up with Dr. on 3/11/22 at 10:30 a.m. On 3/6/22 at 2:38 p.m., Fall F/U: VSS. Resident slept in this morning as she is usually a late riser. Neurological status intact. No ROM impairments per usual. Ambulates with a walker and supervision. No injuries noted due to most recent fall. Stitches to right hand mostly intact with 1 stitch missing. Skin is healing. Resident will not keep dressing in place. Resident is a pleasant mood today and cooperative with cares. On 3/9/22 at 2:31 a.m., Resident noted to be picking at right hand stitches, residents right hand is swollen, purple in color, no foul odor noted at this time. Resident educated on needing to not pull and or pick at stitches in hand due to high risk of infection. Review of the Skin Evaluation Weekly form documented on 3/7/22 at 2:21 a.m., no new findings at this time, skin is normal to ethnicity, Clear/Dry/Intact. Review of the Skin Evaluation Weekly form documented on 3/20/22 at 12:38 p.m.,Resident's skin is Clear/Dry/Intact with no new areas of concern noted. Review of the Skin Evaluation Weekly form documented on 3/27/22 at 11:45 a.m.,No current skin issues.	F 684		

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F 684	Continued From page 13 In an interview on 9/19/22 at 2:45 p.m., the Corporate Nursing Consultant confirmed and verified the clinical record lacked any documentation of skin assessment being done after the fall on Resident #4, and that the expectation of the staff is to do a complete assessment and then to notify the family and the physician right after the fall and not the next day. The Nurse Consultant confirmed it has been an expectation to assess, measure, and document all new skin areas, and visualize at least every week. In an interview on 9/26/22 at 2:45 p.m., the facility Director of Nursing (DON) worked on 2/28/22 and was with the charge nurse when Resident #4 was on the floor. The DON explained the charge nurse was given direction on how to fill out the incident/accident report, make sure to notify the family and physician and to do skin sheets for the skin tears and lacerations on the resident right palm and little finger. The DON stated that when she came back to work on 3/1/22, the Incident/Accident Report was not completed and that the skin sheets were also not completed and the DON had to fill out all the forms and it is an expectation of the nurses to follow the policy and procedures to notify families, physician and to do an assessment on all skin areas and to fill out skin sheets and to do them weekly. On 9/26/22 at 4:00 p.m. the DON confirmed and verified that there are no neuro sheets for Resident #4 in her clinical record and it is an expectation that neuros be completed after an unwitnessed fall 2) According to the MDS assessment dated	F 684		

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F 684	Continued From page 14 2/21/22 Resident #5 scored 9 on the BIMS indicating moderate cognitive impairment. The resident required supervision with bed mobility, transfer, ambulation, dressing, eating, toilet use and personal hygiene. The resident's diagnoses included Alzheimer's disease. The Care Plan initiated 2/16/ 22 identified the resident had the potential for pressure ulcer development related to pain, dementia, and incontinence. Interventions included daily body checks, monitoring abrasion left outer wrist 4/7/22, abrasion to bridge of nose 4/1/22, abrasion to chin 4/7/22, abrasion to left 5th finger, abrasion to left side of forehead, abrasion to left orbital area, bruising to face 4/25/22, bruising left arm 4/25/22, bruising left leg 4/25/22, bruising right arm 4/25/22, bruising right leg 4/25/22, skin tear left elbow 4/1/22, skin tear left forearm 4/1/22, skin tear right elbow 4/1/22, and a weekly head to toe skin at risk assessment. The Progress Notes dated 3/31/22 at 7:25 p.m. noted the resident fell outside in the grass. A visitor witnessed the fall. They assessed the resident for injuries, and range of motion performed with no pain, he did have skin tears on the bridge of his nose. Vitals were within range, neuros started, and the Director of Nursing (DON), family and MD aware. The Progress Notes dated 4/2/22 at 10:48 p.m. documented at 7:30 p.m. a CNA made the charge nurse aware the resident was on the ground outside. Upon assessment, the resident exited the facility without his wheeled walker and fell on the cement. The door alarm alerted staff who then immediately checked the door and observed the resident on the ground outside. The resident	F 684		

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F 684	Continued From page 15 laid face down with his bilateral upper extremities (BUE) at his side and bilateral lower extremities (BLE) extended out. They assessed the resident for indications of major injuries with no indication noted. The resident's vital signs were within normal limits, pupils equal and reactive to light. The resident alert and oriented to self, resident's baseline. The resident had abrasions to the left side of his face and left upper extremity (LUE). The Resident wore shoes. Staff assisted the resident off of the ground into his wheel chair with assist of two and a gait belt. The resident tolerated the activity well. The resident had the following new skin areas: 1) Left fifth digit abrasion 0.4 X 0.8 X 0.1 cm, 2) Left fifth digit knuckle abrasion 1.0 X 1.3 X 0.1 cm, 3) Left outer wrist abrasion 1.1 X 0.6 X 0.1 cm, 4) Left upper side of forehead/scalp abrasion 7.0 X 3.0 X 0.1 cm, 5) Left upper forehead abrasion 2.5 X 2.0 X 0.1 cm, 6) Left eyebrow abrasion 0.3 X 4.0 X 0.1 cm, 7) Left eye area abrasion 2.5 X 5.5 X 0.1 CM 0.1 X 2.0 X 0.1 cm, 9) Bridge of nose abrasion 1.5 X 2.5 X 0.1 cm, 10) Chin abrasion 1.0 X 2.0 X 0.1 cm. All areas were cleansed, patted dry, triple antibiotic (ATB) ointment applied, and covered with non adhesive dressing. Staff were educated to ensure the resident utilized his wheeled walker when ambulating. Staff verbalized understanding. A Weekly Skin Evaluation dated 4/2/22 contained the information in the Progress Notes after the fall. The clinical record lacked any additional assessment off the skin areas or neuro sheets for	F 684		

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F 684	Continued From page 16 post fall assessment. A Weekly Skin Evaluation dated 4/19/22 indicated bruising to the residents face, bilateral arms and legs, and continued monitoring. The evaluation lacked any measuremets or descriptions of the skin impairments. On 9/26/22 at 1:15 p.m. the DON stated she could not find the neuro sheets or skin sheets for the injuries the resident had with the 4/2/22 fall. 3) According to the MDS assessment dated 2/28/22 Resident #12 scored 8 on the BIMS indicating moderate cognitive impairment. The resident required extensive assist with bed mobility, transfer, ambulation, dressing, toilet use and personal hygiene. The resident's diagnoses included lung disease. The resident had a fall/falls prior to admission to the facility, and 1 fall since admission. The Care Plan dated 3/7/22 documented the resident had an actual impairment to skin integrity related to fragile skin and falls. Interventions included keeping the skin clean and dry, using lotion on dry skin, monitoring skin tear to left arm, left leg, right arm, and right leg all dated 3/7/22, and providing skin treatments per the physician's order. The Progress Notes dated 4/5/22 documented at 5:25 a.m. a CNA reported the resident was on the floor in her bathroom. Upon assessment, the resident laid on top of her walker on her left side on the bathroom floor. The resident stated she attempted to go to the bathroom without assistance. The call light remained off. The	F 684		

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resident had bare feet however did wear gripper socks that she removed herself while resting in bed. The call light was attached to her bed within her reach. They assessed the resident and she complained of left hip pain and stated she could not move. They placed a call and the resident transferred to the hospital. The resident had a laceration to the left side of her forehead and her left hand.

A History and Physical dated 4/5/22 at 8:41 a.m. documented the resident came to the emergency room after a fall getting out of bed. The resident hit her head and face. When the resident arrived the nursing staff had to spend an extensive amount of time cleaning the resident up as she was covered in hard, dry stool. The staff at the nursing home stated they didn't know how long the resident laid on the floor. The resident seen originally by the Physicians Assistant and then the Physician. When the Physician received the resident she had already received 2 doses of intravenous Fentanyl 25 mcg and quit comfortable. On arrival she complained of hip pain and had multiple skin tears just lateral to her left eye. The PA took care of the facial laceration with steri strips.

The Progress Notes dated 4/5/22 at 12:25 p.m. documented the resident returned from the ER with new orders for antibiotic, (Doxycycline) for infection. The resident had left side maxillofacial fractures and a suspected non displaced right sacral fracture.

The clinical record lacked assessment of the residents skin injuries or the neuro assessments for a fall with hitting her head. The Assessment tab in Point Click Care (PCC) showed 1 Weekly

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F 684	Continued From page 18 Skin Evaluation done after the fall on 4/5/22. The assessment documented scattered bruises and skin tears on the residents body from recent falls with no measuments or assessment of the areas. On 9/26/22 at 5:10 p.m. the DON stated she could not find the neuro sheet for the 4/5/22 incident, or skin assessments.	F 684	F689 Residents #1,5,10, 12 have updated elopement risk assessments completed and wanderguard in place as appropriate. All residents had updated elopement risk assessments completed and care planned as appropriate, All residents with high risk elopement assessments have wanderguard in place as appropriate and up to date care planning. Nursing educated at meeting on 10/17/22 on elopement risk assessment as well as elopement policy. DNS/ designee will monitor all new residents for correct elopement risk assessment upon admit for next 30 days and elopement drill will be completed on 10/17/ 22 by plant department and nursing will be given education as appropriate.	10/27/22
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 observation, record review and staff interview, the facility failed to provide adequate supervision to prevent residents from leaving the facility unattended/elopement for 2 of 3 residents reviewed (Resident #1 and #5) a fall with injury (Resident #5 and #12) and self inflicted harm (Resident #10). The facility reported a census of 47 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 8/29/22 Resident #1 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident wandered 1 to 3 days during the assessment period. The resident	F 689		

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required supervision with ambulation. The resident had diagnoses including non-Alzheimer's dementia and an anxiety disorder.

The Care Plan initiated 5/31/22 identified the resident with activity of daily living (ADL) self care performance deficit. The interventions included the resident could be independent with her walker, with assistance as needed.

The Care Plan initiated 6/21/22 identified the resident an elopement risk/wanderer related to a history of
attempts to leave the facility unattended. The interventions included checking skin under Wander Guard on left ankle for irritation or redness, documenting wandering behavior and attempted diversional interventions, and monitoring Wander Guard placement on left ankle.

An Elopement/Wandering Evaluation dated 8/30/22 showed the resident at high risk with a score of 17. The assessment included the wandering placed the resident at significant risk of getting to a potentially dangerous place (stairs, outside the facility).

The Progress Notes documented the following:
a. On 8/21/22 at 2:33 p.m. the resident had been wandering through the halls and dining room and exiting out doors; the resident became agitated with redirection.
b. On 8/27/22 at 3:48 p.m. after the noon meal the resident's mood changed and she became agitated yelling at
other residents, wandering the facility and yelling out she would call the police. Staff witnessed the resident walking through the door to the assisted

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living (ALF). The resident became more agitated with redirection but did follow staff back to the nursing home side. The resident continued to wander the dining room.

c. On 8/28/22 7:38 p.m. the resident made several attempts to leave the building during the evening. The resident became physically aggressive with staff, pinching and scratching staff when assisted the resident away from the doors or back into the building.

d. On 8/30/22 at 1:22 p.m. the resident had been pacing throughout facility and attempting to exit the building. Staff attempt to re-direct without success. They would continue to monitor as needed.

e. On 8/30/22 at 8:47 p.m. the resident received medication for being combative, attempting to flee and
refusing all offered nursing interventions/care.

f. On 8/31/22 at 4:43 a.m. the resident very upset on evening shift and went out the kitchen door multiple times and stated she would go home, they could not keep her hostage. While outside she yelled help continuously. After approximately 20 minutes, staff got her back inside at which time she knocked stuff off of tables in the dining room and tore papers up. She went outside again x 2 after which they had one on one with her. The resident refused all evening meds and continued being disruptive, combative and yelling until around 9:30 p.m.

g. On 9/1/22 at 5:53 a.m. the resident very agitated on the evening shift, went outside one time and refused to take any medications. They gave her a snack and tried to redirect. She threw the spoon and ice cream across the room. They had one on one with the resident. She finally went to her room around 9 p.m. In the a.m. the resident had been awake since 3 a.m. She went

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outside 2 times, taking the key out of the door going to the back hallway. She had not been as agitated, but exit seeking, and refused to use her walker. Would have the next shift continue to monitor.

h. On 9/1/22 at 7:01 a.m. the resident ambulated outside through the dining room door agitated with staff attempting to redirect her back inside the building. Staff outside and the resident kept telling staff she would not go back inside.

i. On 9/1/22 at 7:20 p.m. the resident brought back inside the facility via wheelchair with staff assistance and taken to room.

An Incident Report dated 9/1/22 at 8:56 a.m. documented the resident observed outside by a Certified Nursing Assistant (CNA). The resident took the key out of the alarm, and the alarm did not sound. The acting Administrator filled out the report.

The facility investigation included Interviews in regards to the resident's elopement on 9/1/22:
On 9/6/22 Staff B CNA reported she and Staff C CNA were with another resident in hall 1 actively providing cares. They both heard the main alarm sound. Staff B responded to the door alarm and Staff C stayed with the resident to finish cares. Staff B then observed the resident in the parking lot out the dining room window abut 15-20 feet from the door the resident exited. The resident could not be redirected initially to return inside and other staff members provided direct supervision to the resident.
On 9/6/22 Staff G Registered Nurse (RN) reported .the incident occurred around 5:15 to 5:30 a.m. Staff G did not hear the alarm because she performed care with another resident. Staff G visualized the resident sitting at the dining room

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table at the end of hall 5 less than 5 minutes prior to the incident. They could not redirect the resident initially to return inside and other staff members provided direct supervision to the resident.

Staff interviews and observations included:

On 9/6/22 at 1:10 p.m. Staff A Maintenance Supervisor did a walk through to show how alarms were checked. The dining room door to the outside (where elopement occurred) had alarm on the door. A key turned it on/off. Apparently the resident shut the alarm off. He said the door alarm (at the panel) would still work. He said all doors were double alarmed. They did not have a Wander Gard on this door. Not all alarms on the doors were the same. He said he checked the door alarms daily, Mon-Fri. The nurses did them on the weekend unless he was at the facility working. He said the elopement had happened just before before he arrived (that day). He came early because they had a leak. He demonstrated that a piece of plexiglass in front of the alarm box on the wall could be removed to reset the alarms. Wanderguards were on the front door, the door to assisted living, and the door to the outside by the laundry.

On 9/6/22 at 3:35 p.m. Staff B Certified Nursing Assistant (CNA) stated she worked the night shift the resident eloped. She said between 5 and 5:30 a.m. they were doing final rounds. They were in another resident's room on hall 1. The resident had a bowel movement (bm) and they were in the middle of cleaning her up. They decided to finish her up and then go and see what the alarm was about. She said it took 2-5 minutes at the longest to finish cleaning the

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resident. She said before they finished the alarm stopped sounding. When she left the resident's room she walked to the DR area and out of the corner of her eye she saw someone outside. She hollered we have someone outside, and ran out to see the resident. She was 15-20 feet out the door. She did not want to go back inside but she and Staff G got her to go back inside. The nurse came out about 2 minutes after her. She said they did a head count to assure all residents were accounted for. She did not know who shut the alarm off.

On 9/6/22 4:23 p.m. Staff C CNA stated before the elopement occurred the resident had opened the door in the dining room and the alarm sounded at the panel. She kept the resident from going outside. She said no other alarm sounded. She and Staff B were down helping a resident near the end of hall 1. They heard the alarm, and decided they could not leave the resident. So they continued with her cares. Before they finished the alarm stopped. When they had the resident taken care of Staff B left the room and she stayed to clean up. When she went up to the dining room Staff B and the nurse were bringing the resident in, and thought she went to her room.

On 9/7/22 at 8:50 a.m. Staff D Laundry Supervisor stated she came to the facility early (that day) because they had a leak. She did not hear an alarm because of the noise with the machines running. When she came out of the laundry room Staff B told her a resident got out of the facility. Staff B said they heard the alarm and then it stopped like someone shut it off. Staff D said they needed to do a head count and she assisted with that.

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F 689	Continued From page 24 On 9/7/22 at 3:38 p.m. the Administrator and the Director of Nursing (DON) stated they were not aware the 2 CNA's said the door alarm stopped while they were still in with the other resident. On 9/8/22 at 8:54 a.m. Staff E Licensed Practical Nurse (LPN) said when she started her shift at 6 a.m. (9/1/11) the Assistant Director of Nursing (ADON) and Administrator were there and they were supervising the resident who anxiously paced in the dining room. She knew the resident got outside but not a lot of details. The resident acted very agitated so they called the doctor and received orders for something to decrease her agitation. That's about all she knew. On 9/8/22 at 9:32 a.m. Staff F, Laundry stated they had a leak in the laundry that morning and she had called maintenance. She was in the laundry and heard no alarms. She knew what happened when a CNA told her a resident went outside. The CNA said they heard the alarm from the room they were in, and it had stopped sounding. The CNA saw the resident outside. They didn't know if someone shut the alarm off or if it went off on it's own. In a follow up on 9/28/22 at 12:37 p.m. Staff B stated she thought the resident had gripper socks and facility gowns on. She wore 1 front way and 1 backwards to ensure full coverage. She wasn't completely sure due to the time lapse since the incident. She did not talk to the nurse (on duty when the elopement occured) about the incident. On 9/8/22 at 6:35 p.m. Staff G Registered Nurse (RN) (contract Nurse) stated she worked 6 p.m. to 6 a.m. 8/31/22 to 9/1/22. On the evening shift the resident went out the dining room door and	F 689		

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F 689	Continued From page 25 staff saw her and went with her. She did go to bed before 10 and got back up at 3 a.m. She paced. She went out the dining room door about 30 minutes before she eloped. The CNA's were providing care in a room and she had a blood sugar to do. The resident sat at a dining room table and seemed okay at that time. She went to the room to do the blood sugar. She did not hear an alarm. When she went back to the nurse's station another resident told her the resident went outside. She immediately went out and assisted Staff B in getting the resident back in the facility. She didn't know who could have turned the alarm off. She had never seen the other resident do that, but had not been (working) at the facility that long. The other resident did ambulate independently with device. 2) According to the MDS assessment dated 2/21/22 Resident #5 scored 9 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident exhibited wandering 1-3 days during the assessment period. The resident required supervision with bed mobility, transfer, ambulation, dressing, eating, toilet use and personal hygiene. The resident's diagnoses included Alzheimer's disease. The Care Plan initiated 2/16/22 identified the resident at risk for falls related to low back pain, syncope with collapse, and a history of falls. The interventions added before 3/31/22 included: a. Keep items, water, etc, in reach. b. Maintain a clear pathway, free of obstacles. c. Resident to wear shoes or gripper socks at all times. d. Talked to Social Services Designee (SSD)	F 689		

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F 689	Continued From page 26 about referral related to fall/wandering (dated 3/24/22). e. Referral to Dementia unit in Sioux Center, 4/1/22. The clinical record lacked interventions regarding wandering and elopement. The Progress Notes documented: a. On 3/13/22 the resident at the laundry door actively exit seeking. The resident physically pushed staff out of the way in attempts to get out of facility. The resident continued to actively exit seek, and all staff were aware. b. On 3/13/22 at 6:10 p.m. the resident exited the facility through hall 400. Staff witnessed the resident exiting 3 times and assisted to re-enter the facility through the front door. The Wander Guard active and alerted the door. The resident severely agitated, and continued to exit seek. c. On 3/15/22 at 7:04 p.m. the resident took another resident's wheelchair and hitting the nurse with the wheelchair and punching the nurse in the arms. The resident acted aggressive, yelled and swore at the nurse. The resident continued to try and go outside and it took multiple staff members to bring him back. d. On 3/15/22 at 11:13 p.m. the resident was in another resident's room. The resident's family member was here in attempts to re-direct the resident to the correct room. The resident refused to move from the recliner in the other resident's room. The resident hit staff very hard on their backs and chests with his fists. The resident has been actively exit seeking since arrival of shift start at 5:45 p.m. The resident showed no signs of understanding re-direction. The resident managed to exit the facility from door 200, the CNA followed.	F 689		

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F 689	Continued From page 27 e. On 3/16/22 at 3:24 a.m. the resident wandered the hallways in a long sleeve shirt and pull up brief, refusing to put pants on. A CNA closely followed the resident. Re-direction ineffective on all accounts. The resident wore tube socks and no shoes, and a Wander Guard on a lower extremity. All staff made aware to monitor all doors for residents and exits. f. On 3/18/22 at 4:30 a.m. the resident wandered and attempted to exit seek from 11 p.m. to 1 a.m. The resident managed to get through the doors to the assisted living unit 2. times and a CNA assisted him back to the long term care (LTC) side. g. On 3/18/22 at 7 a.m. the resident exit seeking, and got out of the doors 6 times in one hour. Staff did one on one, and it took multiple staff members to redirect the resident out of another resident's room. h. On 3/18/22 at 5:15 p.m. the resident returned from a drive with family, then tried going outside 2 times. The 2nd time he refused to come back in. He left the parking lot and started walking down Ave L with a CNA. The resident's family present at the facility and finally got the resident in her van. The family member came to the parking lot and the resident refused to get out of the van. The nurse received an as needed (PRN) Ativan 0.5 mg one time dose from an Emergency Room (ER) physician. The nurse gave PRN medication, and family would drive around the block and try again to bring the resident back. i. On 3/20/22 21:43 the resident observed to be restless and exit seeking following supper. Was easily redirected by staff and one on one was provided by the charge nurse. After wandering throughout the facility the charge nurse redirected the resident to his room where he sat in his recliner next to his wife.	F 689		

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F 689	Continued From page 28 j. On 3/23/22 at 6:04 p.m. the resident had increased aggression, and trying to leave out hall 4 door with all his clothes from the closet. It took multiple people to redirect him. k. On 3/24/22 at 6:28 p.m. after supper resident went out hall 4 doors. Staff able to redirect him for a few minutes, then 5 minutes later he went out hall 3. It took 3 staff to redirect him back inside, then the nurse did one on one in his room for 20 minutes. l. On 3/28/22 at 5:57 p.m. the resident exit seeking, going out multiple doors, going into other residents room and refusing to leave. It took multiple times to redirect. m. On 3/31/22 at 7:25 p.m. the resident fell outside in the grass. A visitor witnessed the fall. They assessed the resident for injuries, and range of motion performed with no pain, he did have skin tears on the bridge of his nose. Vitals were within range, neuros started, and the Director of Nursing (DON), family and physician aware n. On 4/2/22 at 10:48 p.m. 7:30 p.m. a CNA made the charge nurse aware the resident was on the ground outside. Upon assessment, the resident exited the facility without his wheeled walker and fell on the cement. The door alarm alerted staff who then immediately checked the door and observed the resident on the ground outside. The resident laid face down with his bilateral upper extremities (BUE) at his side and bilateral lower extremities (BLE) extended out. They assessed the resident for indications of major injuries with no indication noted. The resident's vital signs were within normal limits, pupils equal and reactive to light. The resident alert and oriented to self, resident's baseline. The resident had abrasions to the left side of his face and left upper extremity (LUE). The Resident	F 689		

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wore shoes. Staff assisted the resident off of the ground into his wheel chair with assist of two and a gait belt. The resident tolerated the activity well. The resident had the following new skin areas:
1) Left fifth digit abrasion 0.4 X 0.8 X 0.1 cm,
2) Left fifth digit knuckle abrasion 1.0 X 1.3 X 0.1 cm,
3) Left outer wrist abrasion 1.1 X 0.6 X 0.1 cm,
4) Left upper side of forehead/scalp abrasion 7.0 X 3.0 X 0.1 cm,
5) Left upper forehead abrasion 2.5 X 2.0 X 0.1 cm,
6) Left eyebrow abrasion 0.3 X 4.0 X 0.1 cm,
7) Left eye area abrasion 2.5 X 5.5 X 0.1 CM 0.1 X 2.0 X 0.1 cm,
9) Bridge of nose abrasion 1.5 X 2.5 X 0.1 cm,
10) Chin abrasion 1.0 X 2.0 X 0.1 cm.
All areas were cleansed, patted dry, triple antibiotic (ATB) ointment applied, and covered with non adhesive dressing. Staff were educated to ensure the resident utilized his wheeled walker when ambulating. Staff verbalized understanding.

Staff interviews included:
a. On 9/19/22 at 2:20 p.m. Staff H CNA stated she thought the resident went outside and fell 2 times. She said the evening the resident fell on the concrete, he had tried going out hall 3 right before then and she redirected him to the dining room. There were nurses and CNA's at the nurses station so she told them she was going to do something, so they could watch him. She then heard the alarms going off and ran from hall 1 to the dining room and saw the resident going out the hall 4 door. She ran down the hall and by the time she got there he had fallen face down on the parking lot. She yelled for someone to get the nurse. The nurse came and assessed him and they assisted him to his wheelchair. She said they

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were short staffed. Sometimes it was hard to get things done, and supervise residents who needed more.

b. On 9/20/22 at 9:02 a.m. the DON stated they had no investigation related to the falls outside. The alarms sounded, and they went to the door right away. She could not say for sure which door he went out. When asked what was going on prior to the resident going outside, the DON stated he had dementia and he was exit seeking. She did not know what was going on prior to the incidents.

c. On 9/20/22 at 12:46 p.m. Staff J Licensed Practical Nurse (LPN) stated the resident got outside several times. One time he ran down the street, a CNA was with him. She said the night she documented he fell in the grass, she was the only nurse from 2-6 p.m. They had a lot going on. By the time the other nurse came on, she was already behind. The resident had been making attempts to exit the building. She had things to do and she heard a door alarm go off. She saw which door and ran down to it and the resident was by the hill to the right with the downward slope. A visitor was trying to have the resident go back inside. She went and tried to redirect the resident. The resident acted aggressive, fell and dragged the visitor and the nurse down with him. She said there were not enough staff to supervise the residents who had behaviors. She did not document all the specifics of the incident because she had so much else to do. She said they had so many falls because they didn't have enough staff. She said they definitely had a problem with staffing to supervise residents appropriately.

d. On 9/20/22 at 6:27 p.m. Staff I RN stated he worked at the facility 5 weeks, citing his contract was cut short. He recalled the resident getting outside. He did not see him first outside. He did

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F 689	Continued From page 31 assess him and he did have skin injuries. He said they did not have enough staff on the eve shift and could not supervise the residents as they needed. He, and he thought other staff reported it was not safe for the residents, with the staffing they had. They were told they would look into a locked memory care unit for the resident, but they did not. e. On 9/21/22 at 11:52 a.m. Staff M CNA stated she worked multiple times the resident escaped. She did not recall assisting the shift the resident fell in the grass. She said when he fell on the concrete the alarms sounded, but staff were assisting other residents. She held the door when they brought the resident back inside. She said they did not have enough staff to supervise the resident. He usually got exit seeking after the evening meal, he needed increased supervision at that time. f. On 9/21/22 at 3:26 p.m. the SSD stated the resident was on the waiting list at an Assisted Living (AL) when he admitted to the facility. She didn't know if they meant a Memory Care Unit (on the care plan). On 9/21/22 at 3:26 p.m. the SSD came back and said she had no documentation she contacted the memory care unit about placement for the resident. g. On 9/21/22 at 3:30 p.m. Staff N LPN stated she worked the eve the resident fell in the grass (3/31) on the sloped area. She said when she came to work Staff J was crying because she was the only nurse on duty and they usually had 2 nurses 6-2 and 2-10 shifts. She still had reports to write up for falls that had occurred. She went to see if Staff J needed anything after the resident exited the building. Staff J had at least 1 CNA with her. She didn't know anything else about the fall. She said the resident was exit seeking and	F 689		

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F 689	Continued From page 32 needed close supervision. She only worked at the facility a handful of times because there were a lot of residents with behaviors who needed 1 to 1 supervision and they didn't have the staff to do it. The facility Elopement policy revised 10/2007 documented the it was the policy of the facility to provide a safe environment for all residents. The facility would properly assess residents and plan their care to prevent accidents related to wandering behavior or elopement. The procedures included each resident's level of supervision required would be assessed based on observed wandering behaviors. The information would be documented in the resident's medical record, and used in the care planning process. Residents with an elopement incident from the facility either on or off the grounds should be considered higher risk for further attempts at elopement. The residents would have the following precautionary measures implemented to prevent repeat incidents of elopement. Resident's wandering episodes would be tracked and resident specific approaches/interventions added to the care plan as determined effective by the interdisciplinary team. If the resident attempted to leave the facility more than 1 time in a 24 hour period, he would be placed on every 30 minute visual checks for 48 hours. If exacerbation of the behavior continued, 1 to 1 supervision would be considered until the physician could assess the resident for cause. 3) According to the MDS assessment dated 2/28/22 Resident #12 scored 8 on the BIMS indicating moderate cognitive impairment. The resident required extensive assist with bed	F 689		

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F 689	Continued From page 33 mobility, transfer, ambulation, dressing, toilet use and personal hygiene. The resident's diagnoses included lung disease. The resident had a fall/falls prior to admission to the facility, and 1 fall since admission. The Care Plan dated 2/13/22 identified the resident at risk for falls related to restlessness, agitation, dyspnea, and oxygen use. Interventions included bed in lowest position for safety but yet not restrict movement, and toilet resident on last rounds for the night shift initiated 4/1/22. The Progress Notes dated 4/5/22 at 5:52 a.m. documented at 5:25 a.m. a CNA reported the resident on the floor in her bathroom. Upon assessment, the resident laid on top of her walker on her left side on the bathroom floor. The resident stated she attempted to go to the bathroom without assistance. The call light remained off. The resident had bare feet however did wear gripper socks that she removed herself while resting in bed. The call light attached to her bed and within her reach. They assessed the resident and she complained of left hip pain and stated she could not move. They placed a call and the resident transferred to the hospital. The resident had a laceration to the left side of her forehead and her left hand. A History and Physical dated 4/5/22 at 8:41 a.m. documented the resident came to the emergency room after a fall getting out of bed. The resident hit her head and face. When the resident arrived the nursing staff had to spend an extensive amount of time cleaning the resident up as she was covered in hard, dry stool. The staff at the nursing home stated they didn't know how long the resident laid on the floor. The resident seen	F 689		

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F 689	Continued From page 34 originally by the Physicians Assistant and then the Physician. When the Physician received the resident she had already received 2 doses of intravenous Fentanyl 25 mcg (pain medication) and quit comfortable. On arrival she complained of hip pain and had multiple skin tears just lateral to her left eye. The PA took care of the facial laceration with steri strips. A Radiology Results-Final dated 4/5/22 at 7:45 a.m. documented the resident had x-ray of bilateral hips with results of questionable nondisplaced left sacral fracture versus artifact. A computed tomography (CT) scan of the pelvis documented the indication a possible fracture on x-ray with the impression of a suspected nondisplaced right sacral fracture. A CT of the head documented some scalp swelling on the left. A nondisplaced fracture of the left posterolateral maxillary sinus, a nondisplaced fracture of the left anterior maxillary sinus, a nondisplaced fracture of the left orbital floor, possible nondisplaced left zygomatic arch fracture, and a nondisplaced left lateral orbital wall fracture. The Progress Notes dated 4/5/22 at 12:25 p.m. documented the resident returned from ER with new orders for antibiotic (Doxycycline) for infection. The resident had left side maxillofacial fractures and a suspected non displaced right sacral fracture. The clinical record lacked assessment of the residents injuries after the fall or the neuro assessments. On 9/20/22 at 6:27 p.m. Staff I RN stated he did work the night the resident fell. She went to the	F 689		

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F 689	Continued From page 35 hospital and returned the next shift. He did not know when the last time staff saw the resident prior to the incident. On 9/20/22 at 9:02 a.m. the DON stated they had no investigation related to the fall on 4/5/22. On 9/26/22 at 1:15 p.m. the DON stated Staff O CNA documented at 4:58 a.m. (4/5/22) resident cares. She said they documented 1 time per shift, so she didn't know what time they were done. They put the intervention for toileting the resident on last rounds after a fall on 3/28/22. On 9/26/22 at 4:22 p.m. Staff O CNA said she did the charting 4/5/22 on the night shift, but they did it when they could. She didn't recall taking her to the bathroom except in the evening. She worked 6p-6a. She did not find the resident, another CNA did, but she went to help. The resident had a bowel movement (bm) and she wanted to clean her up, but the nurse said no because they did not know the extent of her injuries. 4. The Quarterly MDS with an assessment reference dated 7/19/22, documented Resident #10 with a BIMS score of 15 for which indicated no impairment with daily decision making abilities, and was able to be understood and had the ability to understand others. The MDS documented the resident required supervision of set up help with activities of daily living. The MDS documented Resident #10 with diagnosis for which included hypertension, diabetes mellitus, anxiety, depression, schizophrenia, history of non-suicidal of self-harm, borderline personality disorder and	F 689		

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F 689	Continued From page 36 sleep disorder. A Physicians Order dated and signed 8/5/22, instructed staff to do constant 1-1 supervision with all sharp objects removed from room. A Progress Note dated 8/8/2022 at 9:53 p.m., documented, No 1:1 for resident for 10 minutes. Resident came to dining area and waited for staff to leave nurses station and returned to her room. Writer goes back to nurses station and notes resident not at dining table. Writer looks down hallway and notices residents door shut. Writer goes to residents room and opens door. Resident noted sitting in her recliner, resident quickly pulls down her left sleeve. Writer assesses site and notes resident has removed bandage et dressing, et was picking at sutures trying to remove them. Writer redirects and educates resident. Resident returns to dining area. Writer redresses site and educates resident to leave site be so it can heal. Resident sitting at dining table drinking a soda and eating chips.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725	F725 Resident #5 has no further episodes of attempting to leave facility. Staffing has been turned over to HR staffing scheduler and consistent staffing patterns have been established as well as using outside agency staff to maintain level of staffing needed to meet resident needs. All residents' needs are being met by daily review of staffing hours and acuity by ED/DNS and designee. Staffing hours are presented daily at morning meeting by HR scheduler and adjustments are made on a weekly basis with new admits and discharges. ED/designee will review staffing weekly and educate HR/scheduler as appropriate x 3 weeks.	10/27/22

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	165245	A. BUILDING _____ B. WING _____	C 09/27/2022

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F 725	Continued From page 37 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to provide sufficient staffing to assure resident safety from falls and elopement for 1 of 9 residents reviewed (Resident #5). The facility reported a census of 47 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 2/21/22 Resident #5 scored 9 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident exhibited wandering 1-3 days during the assessment period. The resident required supervision with bed mobility, transfer, ambulation, dressing, eating, toilet use and personal hygiene. The resident's diagnoses included Alzheimer's disease. The Care Plan identified the resident at risk for falls related to low back pain, syncope with collapse, and a history of falls initiated 2/16/22.	F 725		

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F 725	Continued From page 38 The interventions added before 3/31/22 included: a. Keep items, water, etc, in reach b. Maintain a clear pathway, free of obstacles. c. Resident is to wear shoes or gripper socks at all times. d. Talked to Social Services Designee (SSD) about referral related to fall/wandering (dated 3/24/22). e. Referral to Dementia unit in Sioux Center, 4/1/22. The clinical record lacked interventions regarding wandering and elopement. The Progress Notes documented: d. On 3/15/22 at 11:13 p.m. the resident was in another resident's room. The resident's family member was here in attempts to re-direct the resident to the correct room. The resident refused to move from the recliner in the other resident's room. The resident had hitting staff very hard on their backs and chests with his fists. The resident has been actively exit seeking since arrival of shift start at 5:45 p.m. The resident showed no signs of understanding re-direction. The resident managed to exit the facility from door 200, the CNA followed. f. On 3/18/22 at 4:30 a.m. the resident wandered and attempted to exit seek from 11 p.m. to 1 a.m. The resident managed to get through the doors to the assisted living unit 2 times and a CNA assisted him back to the long term care (LTC) side. g. On 3/18/22 at 7 a.m. the resident exit seeking, and got out of the doors 6 times in one hour. Staff did one on one, and it took multiple staff members to redirect the resident out of another resident's room. h. On 3/18/22 at 5:15 p.m. the resident returned	F 725		

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F 725	Continued From page 39	F 725		

from a drive with family, then tried going outside 2 times. The 2nd time he refused to come back in. He left the parking lot and started walking down Ave L with a CNA. The family present at the facility and finally got the resident in her van. The family member came to the parking lot and the resident refused to get out of the van. The nurse received an as needed (PRN) Ativan 0.5 mg one time dose from an Emergency Room (ER) physician. The nurse gave the PRN medication, and family would drive around the block and try again to bring the resident back.

h. On 3/24/22 at 6:28 p.m. after supper the resident went out hall 4 doors. Staff able to redirect him for a few minutes, then 5 minutes later he went out hall 3. It took 3 staff to redirect him back inside, then the nurse did one on one in his room for 20 minutes.

i. On 3/28/22 at 5:57 p.m. the resident exit seeking, going out multiple doors, going into other residents room and refusing to leave. Took multiple times to redirect.

j. On 3/31/22 at 7:25 p.m. the resident fell outside in the grass. A visitor witnessed the fall. They assessed the resident for injuries, and range of motion performed with no pain. The resident did have skin tears on the bridge of his nose. Vitals were within range, neuros started, and the Director of Nursing (DON), family and MD aware. k.

k. On 4/2/22 at 10:48 p.m.the Progress Notes documented at 7:30 p.m. a CNA made the charge nurse aware the resident was on the ground outside. Upon assessment, the resident exited the facility without his wheeled walker and fell on the cement. The door alarm alerted staff who then immediately checked the door and observed the resident on the ground outside. The resident laid face down with his bilateral upper extremities

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F 725	Continued From page 40 (BUE) at his side and bilateral lower extremities (BLE) extended out. They assessed the resident for indications of major injuries with no indication noted. The resident's vital signs were within normal limits, pupils equal and reactive to light. The resident alert and oriented to self, resident's baseline. The resident had abrasions to the left side of his face and left upper extremity (LUE). The Resident wore shoes. Staff assisted the resident off of the ground into his wheel chair with assist of two and a gait belt. The resident tolerated the activity well. The resident had the following new skin areas: 1) Left fifth digit abrasion 0.4 X 0.8 X 0.1 cm, 2) Left fifth digit knuckle abrasion 1.0 X 1.3 X 0.1 cm, 3) Left outer wrist abrasion 1.1 X 0.6 X 0.1 cm, 4) Left upper side of forehead/scalp abrasion 7.0 X 3.0 X 0.1 cm, 5) Left upper forehead abrasion 2.5 X 2.0 X 0.1 cm, 6) Left eyebrow abrasion 0.3 X 4.0 X 0.1 cm, 7) Left eye area abrasion 2.5 X 5.5 X 0.1 CM 0.1 X 2.0 X 0.1 cm, 9) Bridge of nose abrasion 1.5 X 2.5 X 0.1 cm, 10) Chin abrasion 1.0 X 2.0 X 0.1 cm. All areas were cleansed, patted dry, triple ATB ointment applied, and covered with non adhesive dressing. Staff were educated to ensure the resident utilized his wheeled walker when ambulating. Staff verbalized understanding. On 9/19/22 at 2:20 p.m. Staff H CNA stated she thought the resident went outside and fell 2 times. She said the evening the resident fell on the concrete, he had tried going out hall 3 right before then and she redirected him to the dining room.	F 725		

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F 725	Continued From page 41 There were nurses and CNA's at the nurses station so she told them she was going to do something, so they could watch him. She then heard the alarms going off and ran from hall 1 to the dining room and saw the resident going out the hall 4 door. She ran down the hall and by the time she got there he had fallen face down on the parking lot. She yelled for someone to get the nurse. The nurse came and assessed him and they assisted him to his wheelchair. She said they were short staffed. Sometimes it was hard to get things done, and supervise residents who needed more. On 9/20/22 at 12:46 p.m. Staff J Licensed Practical Nurse (LPN) stated the resident got outside several times. One time he ran down the street, a CNA was with him. She said the night she documented he fell in the grass, she was the only nurse from 2-6 p.m. They had a lot going on. By the time the other nurse came on, she was already behind. The resident had been making attempts to exit the building. She had things to do and she heard a door alarm go off. She saw which door and ran down to it and the resident was by the hill to the right with the downward slope. A visitor was trying to have the resident go back inside. She went and tried to redirect the resident. The resident was aggressive, fell and dragged the visitor and the nurse down with him. She said there were not enough staff to supervise the residents who had behaviors. She did not document all the specifics of the incident because she had so much else to do. She said they had so many falls because they didn't have enough staff. She said they definitely had a problem with staffing to supervise residents appropriately. On 9/20/22 at 6:27 p.m. Staff I RN stated he	F 725		

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F 725	Continued From page 42 worked at the facility 5 weeks, citing his contract was cut short. He recalled the resident getting outside. He did not see him first outside. He did assess him and he did have skin injuries. He said they did not have enough staff on the eve shift and could not supervise the residents as they needed. He, and he thought other staff reported it was not safe for the residents, with the staffing they had. They were told they would look into a locked memory care unit for the resident, but they did not. On 9/21/22 at 11:52 a.m. Staff M CNA stated she worked multiple times the resident escaped. She did not recall assisting the shift the resident fell in the grass. She said when he fell on the concrete the alarms sounded, but staff were assisting other residents. She held the door when they brought the resident back inside. She said they did not have enough staff to supervise the resident. He usually got exit seeking after the evening meal, he needed increased supervision at that time. On 9/21/22 at 3:26 p.m. the Social Services Designee (SSD) stated the resident was on the waiting list at an Assisted Living (AL) when he admitted to the facility. She didn't know if they meant a Memory Care Unit (intervention on care plan). On 9/21/22 at 3:26 p.m. the SSD came back and said she had no documentation she contacted the memory care unit about placement for the resident. On 9/21/22 at 3:30 p.m. Staff N LPN stated she worked the eve the resident fell in the grass (3/31) on the sloped area. She said when she came to work Staff J was crying because she was	F 725		

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F 725	Continued From page 43 the only nurse on duty and they usually had 2 nurses 6-2 and 2-10 shifts. She still had reports to write up for falls that had occurred. She went to see if Staff J needed anything after the resident exited the building. Staff J had at least 1 CNA with her. She didn't know anything else about the fall. She said the resident was exit seeking and needed close supervision. She only worked at the facility a handful of times because there were a lot of residents with behaviors who needed 1 to 1 supervision and they didn't have the staff to do it. The Facility Assessment reviewed 8/4/22, documented the facilities commitment to having sufficient staff to meet the needs of the residents at any given time. The general approach to staffing in light of their resident population, and their needs for care and support was to consider the number of residents in the facility and the existing level of acuity for the purpose of computing and scheduling nursing hours.	F 725		

Hillcrest Health Care
Policy/Procedure – Nursing Clinical

Section: **Routine Procedures**

Subject: **Perineal Care**

POLICY:

It is the policy of this facility to:

1. Cleanse perineum
2. Eliminate odor
3. Prevent irritation or infection
4. Enhance resident's self-esteem

PROCEDURES:

Equipment

- Washcloth and towel
- Soap or other cleansing agent
- Wash basin or sink

(Disposable wipes may be used as a substitute for soap and water)

1. Use a screen for resident privacy.
2. Identify resident.
3. Explain procedure.
4. Gather necessary equipment.
5. Wash hands properly.

NOTE: The basic infection control-concept for pericare is to wash from the cleanest area to the dirtiest area.

FEMALE – WITHOUT CATHETER

1. Position resident on back with knees bent and slightly apart.
2. Expose perennial area.
3. Wet washcloth and soap lightly. Fold into a mitt. If using other cleansing agent, use according to manufacturer's instructions.
4. Wash pubic area, including upper, inner aspect of both thighs and frontal portion of perineum.
   A. Use long strokes from the most anterior down to the base of the labia. (Wash from the cleanest area to the dirtiest area.)
   B. After each stroke, refold the cloth to allow use of another area.
5. Follow same sequence for rinsing area.

6. Dry area thoroughly.
7. Instruct or assist resident to turn on side with top leg slightly bent.
8. Rinse cloth and soap lightly.
9. Wash perennial area thoroughly, with each stroke beginning at the base of the labia and extending up over the buttocks.
   A. Refold cloth, as before, to provide clean area.
   B. Washing should alternate side to side, ending with the center anal area.
10. Rinse cloth and entire area in same sequence as above.
11. Dry area thoroughly and then leave resident comfortably positioned.

FEMALE – WITH CATHETER

1. When washing anterior perineum, hold catheter tubing to one side against a leg without causing traction of the urethra.
2. Wash, rinse, and dry tubing during procedure, giving particular attention to juncture of tubing and urinary meatus.

MALE – WITHOUT CATHETER

1. Wash pubic area, including upper inner aspect of thighs as well as the penis and scrotum.
2. Retract foreskin of the uncircumcised male and wash carefully to remove secretions.
3. Wash area under scrotum.
4. Rinse area on same sequence.
5. Dry area carefully, remembering to draw foreskin of the uncircumcised male back over the head of the penis.
6. Instruct or assist resident to turn on side with upper leg slightly bent.
7. Rinse cloth and proceed with cleansing of the anal area, as described above.

MALE – WITH CATHETER

1. Hold catheter tubing to one side, as described above.
2. Wash, rinse, and dry tubing during procedure, giving particular attention to juncture of tubing and urinary meatus.

FOR ALL VARIATIONS, COMPLETE PROCEDURE AS FOLLOWS:

- Discard equipment or return it to the appropriate location.
- Wash hands properly.
- Document all appropriate information in medical record.

Perineal Care

Name of Employee/Learner:_____ **Position:**_____

Signature of Employee/Learner:_____

Date of Hire: _____ **Initial:** _____ **Annual:** _____

Name of Observer/DNS or Designee: _____

Signature of Observer/DNS or Designee:_____

The following table lists the steps that are expected of you in order to properly perform perineal care. The table also provides rationales that explain why you perform some of these steps. Reference: Perry, A., Potter, P. & Ostendorf, W. (Eds.). (2018). Clinical nursing skills & techniques (9th ed.). St. Louis, MO: Elsevier. Disclaimer: The use of this content is for educational purposes only and should only be used as a guide in performing the below skill, subject to the terms and conditions of the Master Services Agreement.

Met	Not Met	Title	Description	Rationale
☐	☐	Patient Identification	Identify patient identifiers per organizational policy.	Ensures the correct patient. Complies with The Joint Commission standards and improves patient safety (TJC, 2016)
☐	☐	Procedure	Assess environment for safety (e.g., check room for spills, make sure that equipment is working properly and that bed is in locked, low position.	Identifies safety hazards in patient environment that could cause or potentially lead to harm (QSEN, 2014).
☐	☐	Hand Hygiene	Perform hand hygiene. Apply clean gloves. Place basin with warm water and cleansing solution on over-bed table.	Prevents transmission of microorganisms. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature
☐	☐	Gloves	Put on Gloves	
☐	☐	Privacy	Assemble supplies. Provide privacy and explain procedure and importance in preventing infection.	Maintains patient's right to privacy. Ensures an organized procedure.
☐	☐	Position	Position the bed at a comfortable working height. Ensure the wheels are locked and the opposite side rail is raised.	Promotes Good body mechanics. When bed is flat, patient can be moved without working against gravity
☐	☐	Procedure	Offer the patient the bedpan or urinal.	Bathing often stimulates the urge to urinate. If the person uses the bedpan, empty and clean it before proceeding with perineal care.
☐	☐	Procedure	If patient is able to maneuver and handle washcloth, allow him or her to clean perineum on his own.	Patient is able to manage self-care.
☐	☐	Procedure	Help patient into position, note restrictions in mobility. For female patient help her assume dorsal recumbent position. For male patient, help him assume supine position.	Provides access to patient.
☐	☐	Position	Ask the patient to open their legs and bend their knees.	
☐	☐	Position	Position a towel or disposable protector pad under the patient's buttocks to prevent other linen from soiling.	Prevents soiling of bed linens.

☐	☐	Procedure	Drape patient with bath blanket, exposing upper thighs.	Maintains warmth and privacy.
☐	☐	Procedure	Wash and dry patient's upper thighs, covering thighs with bath towels once finished.	Maintains warmth and privacy.
☐	☐	Procedure	Raise bath blanket to expose the perineal area.	Exposes perineal area for cleansing.
☐	☐	Procedure	Apply soap to a wet washcloth.	
☐	☐	Procedure	Wash the perineal area. Wipe in only one direction, from front to back and from center to thighs. Change washcloths as necessary.	Reduces transmission of bacteria.
☐	☐	Procedure	Female: Separate labia. Wash urethral area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke. Note: Never wipe upward from the anus.	Washes pathogens away from the meatus. Removes secretions from beneath foreskin which may cause infection and odor.
☐	☐	Procedure	Male: Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning at urethra. Continue washing down the penis to the scrotum and inner thighs.	Removes secretions from beneath foreskin which may cause infection and odor.
☐	☐	Procedure	With fresh water and a clean washcloth, rinse the area thoroughly with the same strokes.	Reduces transmission of bacteria.
☐	☐	Procedure	Gently pat the area dry in the same direction.	Removes secretions in skin folds which may cause infection and odor.
☐	☐	Procedure	Turn the patient onto their side so that they are facing away from you and the buttocks is exposed.	Water used during washing contains soap and pathogens. Soap left on the body can cause irritation and discomfort.
☐	☐	Procedure	Apply soap to a wet washcloth.	
☐	☐	Procedure	Clean the rectal area, wiping in strokes from the base of the labia or scrotum and over the buttocks. Use a different part of the washcloth each time, until the anal area is clean.	Reduces transmission of bacteria.
☐	☐	Procedure	Rinse and dry the anal area thoroughly. Remove the disposable pad from underneath the patient.	Provides comfort.
☐	☐	Position	Assist the patient back into a comfortable position.	Maintains patient comfort.
☐	☐	Safety	Perform final safety measures (i.e. lower bed height and position side rails as appropriate, place call light and water within patient's reach, ask patient if anything else is needed, thank patient).	Safety and comfort measures ensure compliance with the plan of care, standards of practice, and organizational policy, as well as provide security and pleasure to the patient.
☐	☐	Hand Hygiene	Remove gloves and perform hand hygiene.	Prevents transmission of microorganisms.
☐	☐	Documentation	Document the care in the patient's chart.	What you write is a legal record of what you did. If you don't document it, legally it did not happen.

☐ **Perineal Care Requirements Met**

☐ **Perineal Care Requirements NOT Met**

Hillcrest Health Care

Policy/Procedure

Section: **Care and Treatment**

Subject: **Rounds, Licensed Staff**

POLICY:

It is the policy of this facility to ensure the safety and comfort of the resident and to assist in continuity of care and to identify potential change in condition.

PROCEDURES:

1. Residents will be checked by the nursing staff a minimum of every two (2) hours.
2. Observe resident for privacy, dignity and safety.
3. Note positioning, incontinence, proper placement of Foley, IV's, feeding tube, safety and special devices in place & call lights are within resident's reach.
4. Observe grooming and dressing, hair combed (men and women) oral care and lack of odor.
5. Observe residents unit for neatness and cleanliness
6. Observe the physical plant for a clean and dry floor. Report maintenance/housekeeping concerns to appropriate department.

Weekly CNA Rounds Audit

Date:_____ Shift:_____ CNA:_____

All Residents shaved, hair combed neatly and Dry (or appear to have been recently changed)	YES	NO	COMMENTS
Resident in clean clothing with clean bed linen			
Resident room odor free			
Resident room neat and tidy Garbage emptied, room free of old food, room trays			
Call light within reach			
Wheelchair clean and odor free			
Devices in place-remote, phone, books/magazines			
Fingernails clean and trimmed			

Date:_____ Shift:_____ CNA:_____

All Residents shaved, hair combed neatly and Dry (or appear to have been recently changed)	YES	NO	COMMENTS
Resident in clean clothing with clean bed linen			
Resident room odor free			
Resident room neat and tidy, garbage emptied, room free of old food, room trays			
Call light within reach			
Wheelchair/walker clean and odor free			
Devices in place-remote, phone, books/magazines			
Fingernails clean and trimmed			

Date:_____ Shift:_____ CNA:_____

All Residents shaved, hair combed neatly and Dry (or appear to have been recently changed)	YES	NO	COMMENTS
Resident in clean clothes with clean linen			
Resident room odor free			
Resident room neat and tidy, garbage emptied, room free of old food, room trays			
Wheelchair/walker clean and odor free			
Call light within reach			
Devices in place-remote, phone, books/magazines			
Fingernails clean and trimmed			

Date:_____ Shift:_____ CNA:_____

All Residents shaved, hair combed neatly and Dry (or appear to have been recently changed)	YES	NO	COMMENTS
Resident in clean clothes with clean linen			
Resident room odor free			
Resident room neat and tidy, garbage emptied, room free of old food, room trays			
Wheelchair/walker clean and odor free			
Call light within reach			
Devices in place-remote, phone, books/magazines			
Fingernails clean and trimmed			

All Residents shaved, hair combed neatly and Dry (or appear to have been recently changed)	YES	NO	COMMENTS
Resident in clean clothes with clean linen			
Resident room odor free			
Resident room neat and tidy, garbage emptied, room free of old food, room trays			
Wheelchair/walker clean and odor free			
Call light within reach			
Devices in place-remote, phone, books/magazines			
Fingernails clean and trimmed			

All Residents shaved, hair combed neatly and Dry (or appear to have been recently changed)	YES	NO	COMMENTS
Resident in clean clothes with clean linen			
Resident room odor free			
Resident room neat and tidy, garbage emptied, room free of old food, room trays			
Wheelchair/walker clean and odor free			
Call light within reach			
Devices in place-remote, phone, books/magazines			
Fingernails clean and trimmed			

Date:____________ Shift:_________ CNA:______________________

Hillcrest Health Care
Policy/Procedure – Nursing Clinical

Subject: **Change of Condition Reporting**

POLICY:

It is the policy of this facility that all changes in resident condition will be communicated to the physician and documented

PURPOSE:

To clearly define guidelines for timely notification of a change in resident condition.

PROCEDURES:

Life Threatening Change

1. Licensed nurse will initiate appropriate first aid measures until emergency response personnel arrive on the scene.

2. Licensed nurse will inform the primary physician (alternate physician or Medical Director) of resident status as soon as possible once resident needs have been met and immediacy of nursing care is completed.

3. Licensed nurse will inform family/ responsible party of change of condition and document notification.

4. All nursing actions, physician contacts and resident assessment information will be documented in the nursing progress notes.

Acute Medical Change

1. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician.

2. If unable to contact attending physician or alternate physician timely, notify Medical Director for follow-up to change in resident condition.

3. The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken.

4. All nursing actions will be documented in the licensed progress notes as soon as possible after resident needs have been met.

Routine Medical Change

1. Unusual signs and symptoms will be communicated to the physician promptly. Routine changes are minor changes in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening.

2. The nurse in charge is responsible for notification of physician prior to end of assigned shift when a significant change in resident's condition is noted.

3. If unable to reach physician, all calls to physicians or exchanges requesting callbacks will be documented on the nursing progress notes.

4. If the physician has not returned the call by the end of the shift, the on-coming nurse will be notified for follow-up.

5. If unable to contact attending physician or alternate timely, notify Medical Director for response and follow-up to change in resident status.

6. Document resident change of condition and response in nursing progress notes and update resident Care Plan, as indicated.

7. All attempts to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response.

Care Planning:

1. Comprehensive Care Plan will be updated/ revised accordingly.

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CHANGE OF CONDITION AUDIT

RESIDENT'S NAME (RM.)/DATE OF COC	CHANGE IN CONDITION	DOCUMENTATION IS Q SHIFT x 72 HOURS	TIMELY IDENTIFICATION	FAMILY/MD WAS NOTIFIED IMMEDIATELY	CAREPLAN UPDATED/RESOLVED	INCIDENT REPORT COMPLETED	TIMELY IDENTIFICATION COC/MDS COMPLETED	BED HOLD POLICY GIVEN ON ADMIT/TRANSFER	NOTICE GIVEN ROOM CHANGE/ROOMATE CHANGE	EARLY DETECTION/ASSESMENTS/INTERVENTIONS
TOTAL	0	0	0	0	0	0	0	0	0	0

Hillcrest Health Care
Policy/Procedure

Section: **Administration**

Subject: **Elopement**

POLICY:

It is the policy of this facility to ensure that the facility provides a safe and secure atmosphere for all residents in the facility.

PURPOSE:

To ensure that residents at risk for elopement are properly monitored
To ensure that residents that do leave the facility are located quickly and safely.

PROCEDURES:

1. Residents who are at risk for elopement will have an appropriate plan of care developed to address the risk.

2. When an elopement is suspected and the resident cannot be found, the Licensed Nurse will announce "Team Time immediately to do head count." Charge nurse will direct staff during potential elopement.

3. Upon locating the resident, the Licensed Nurse will cancel the head count.

4. All available staff shall begin a search of the facility grounds (inside and outside) to locate the resident. This search shall include all resident rooms in the facility or any other place an adult could hide (including behind locked doors).

5. In the event that the resident cannot be located within the confines of the facility grounds, the Licensed Nurse shall initiate the following procedure:

    A. The DNS and/or Administrator shall be promptly notified.
    B. Notify the police and request the presence of an officer at the facility to take a missing person report. The police will need a photograph of the resident if available from the chart and a physical description. Be sure to include what the resident was wearing, the resident's current cognitive status and when any staff member last saw the resident.
    C. Notify the attending physician.
    D. Notify the responsible party/surrogate/legal conservator.

E. Staff member shall begin a perimeter search within at least a one-mile radius of the facility either by foot or by car. Staff shall go in pairs in case the resident has any physical/mental crisis to address.

6. The Licensed Nurse shall document all appropriate information in the clinical record before he or she ends his or her shift. All charting and reports must be complete before leaving. This shall include but not be limited to:

   A. When the resident was last seen and by whom
   B. What the resident's mental/cognitive status was prior to the elopement
   C. State the names of all persons called and the time. Include the badge number of the police officer and the time he arrived to take the report and the time that the facility notified the police and who was spoken to (which dispatcher).
   D. Complete all appropriate reports per facility policy for unusual occurrences.
   E. Update the plan of care ONLY IF WARRANTED.

7. When the resident is located and/or returned to the facility, the individuals notified of the resident's absence shall be notified when whereabouts is known.

	Title:	**Skin and Wound Monitoring and Management**

Policy & Procedure	Facility:
	ROP Section: **483.25 Quality of Care**
	Original Date: 03.2015 Revision/Review Date(s): 12.2019; 1.2022

Policy

It is the policy of this facility that:

1. A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and
2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.

Purpose

The purpose of this policy is that the facility provides care and services to:

1. Promote interventions that prevent pressure injury development;
2. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible); and
3. Prevent the development of additional, avoidable pressure injury.

Current evidence documents that, in certain circumstances, the development of pressure injury is an unavoidable occurrence. In accordance with the guidance issued by the National Pressure Ulcer Advisory Panel (March 2010), the facility recognizes that an "unavoidable" pressure injury is one that developed even though the provider evaluated the individual's clinical condition and pressure injury risk factors; defined and implemented interventions that are consistent with individual needs goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

Facility nursing staff will identify and document in the resident's clinical records, the condition and pressure injury risk factors related to the development of unavoidable pressure injury. This identification and implementation of a plan of care will begin at admission with the initial care plan and be completed throughout assessment process for developing a comprehensive plan of care.

Definitions

Pressure Injury: localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Pressure injuries are staged to indicate the extent of tissue

damage. The stages were revised based on questions received by NPUAP from clinicians attempting to diagnose and identify the stage of pressure injuries.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin, which may appear differently in darkly pigmented skin. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration as these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled round edges) are often present. Slough and/or eschar may be visible. he depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

Deep Tissue Pressure Injury: Intact or non-intact skin with persistent non-blanchable deep red, maroon or 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 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 DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Medical Device Related Pressure Injury: This describes an etiology and uses the staging system to stage. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the patters or shape of the device. The injury should be staged using the staging system.

Mucosal Membrane Pressure Injury: Found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged or accurately measured.

Procedure

a. **Resident Assessment:** The nurse responsible for assessing and evaluating the resident's condition on admission and readmission is expected to take the following actions:
   a. Complete Initial Admission Record and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time.
   b. Braden Scale should be completed on admission; quarterly; and following a change in the resident's condition.
   c. Identify risk factors which relate to the possibility of skin breakdown and/or the development of pressure injury which include, but are not limited to:
      - Impaired/decreased mobility and decreased functional ability
      - Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus
      - Drugs, such as steroids, that may affect wound healing
      - Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency
      - Resident refusal of some aspects of care and treatment
      - Cognitive impairment
      - Exposure of skin to urinary and fecal incontinence
      - Nutrition, malnutrition, and hydration deficits
      - History of a healed pressure injury and its stage (if known)
   d. All risk factors identified on assessment should be documented in the resident's clinical record and, when appropriate, be addressed through a care plan.
   e. Develop an individualized person-centered care plan based on the assessment and designed to minimize the possibility of skin breakdown.
   f. Skin and wound assessment on admission and readmission:
      - A licensed nurse must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings, will be documented on the Initial Admission Record.
      - A licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include but not be limited to:
        1) Measuring the skin injury
        2) Staging the skin injury (when the cause is pressure)
        3) Describing the nature of the injury (e.g., pressure, stasis, surgical incision)

4) Describing the location of the skin alteration

5) Describing the characteristics of the skin alteration

g. Ongoing Skin and Wound Assessments:

- A licensed nurse will assess/evaluate a resident's skin at least weekly.
- Areas of breakdown, excoriation, or discoloration, or other unusual findings (either initially identified at the time of admission or as new findings) must be documented in the nursing notes or on the appropriate weekly assessment form. (Skin Pressure Ulcer Weekly, Skin Ulcer Non-Pressure Weekly, or Skin Evaluation - PRN/Weekly)
- A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to:

  1) Measuring the skin injury

  2) Staging the skin injury (when the cause is pressure)

  3) Describing the nature of the injury (e.g., pressure, stasis, surgical incision)

  4) Describing the location of the skin alteration

  5) Describing the characteristics of the skin alteration

  6) Describing the progress with healing, and any barriers to healing which may exist

  7) Identifying any possible complications or signs/symptoms consistent with the possibility of infection

h. It is understood that a resident may experience pain associated with the presence of a skin injury and/or any form of skin compromise. Therefore, the nursing staff shall be responsible to assess the resident for complaints of pain on assessment, prior to treatment, and as appropriate.

i. Once an area of alteration in skin integrity has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order.

j. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered.

2. Suggestions for Measuring:

a. Position the resident in a consistent neutral position for wound measurement.

b. Select a uniform, consistent method for measuring wound length and width to facilitate meaningful comparisons of wound measurements across time.

c. Use a disposable measuring device and/or a cotton-tipped applicator.

d. Determine longest length head to toe and greatest width of each pressure ulcer.

e. Using a similar approach, measure the longest width (perpendicular to the length forming a +, side to side).

f. Measure every pressure ulcer at every stage (Stage 1, Stage 2, Stage 3, Stage 4) and unstageable.

g. Assessment of the pressure injury for tunneling and undermining is an important part of the complete pressure injury assessment.

3. **Prevention:** In order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan:
    a. Stabilize, reduce or remove any existing any underlying risks.
    b. Monitor impact of interventions and modify interventions as appropriate based on any identified changes in condition.
    c. Reposition the resident.
    d. Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc.)
        - CNA's will review electronic Kardex to view care plan interventions.
        - Licensed nurse to document presence of pressure reducing devices on Treatment Administration Records as ordered.
    e. Use transfer techniques which minimize friction and skin tears/shear (mechanical lift).
    f. If the resident is incontinent, make sure that his/her skin remains clean and dry with regular peri-care and toileting when appropriate.
    g. Maintain or improve nutrition and hydration status.
        - Involve the Registered Dietician in care planning process directed to wound prevention and healing.
4. **Documentation**
    a. Pressure Ulcer, Non-pressure Ulcer, and PRN/Weekly skin assessment/evaluation forms:
        - If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative note documenting that notification.
    b. Weekly Skin Check
        - Licensed nurse should document skin evaluations in accordance with this policy and document on the appropriate skin assessment/evaluation weekly/PRN form.
5. **Treatment**
    a. Continue preventive measures as appropriate, including but not limited to:
        - Pressure reduction
        - Continence care
        - Mobility
        - Nutrition management
        - Hydration management
    b. Re-evaluate existing treatment regimen in connection with the resident's clinical presentation, to include current interventions and care plan considerations, if any wound is non-healing or not showing signs of improvement after 14 days or any time a wound is worsening.
6. **Monitoring**
    a. **Daily via medication administration and treatment administration records**

- Confirm all orders have been implemented as ordered.

b. **Weekly via Skin Weekly Committee**

- Prepare and maintain Skin Committee Review Notes and Recommendations in the resident's clinical record.
- Document and implement recommended additions or changes to care plan in resident clinical record.
- Review Report for accuracy of documented devices used.

c. **Skin Inspection on Showering**

- On shower days, CNAs to observe resident skin.
- Identify any areas of skin breakdown, discoloration, tears or redness.
- Communicate findings to licensed nurse:

  1) Verbally

  2) In writing, via "Skin Observation - Shower" form
- Licensed nurse to acknowledge findings, document pertinent information on resident's clinical record, and respond/obtain and implement treatment order as appropriate.

d. **Weekly skin check conducted by a licensed nurse**

- All residents will have a head to toe skin check performed at least weekly by a licensed nurse.
- The licensed nurse should document the findings
- Any skin issues identified as a result of the weekly skin check should be documented and responded to as outlined above

e. **Weekly for those residents admitted with a dressing to a wound or cast/splint to an extremity, or who receive a dressing to a wound or cast/splint to an extremity during the course of the facility admission**

- When a resident is admitted with, or returns to the facility with, a dressed wound or a cast/splint that is being managed outside the facility, nursing staff shall assess and evaluate the dressed/casted/splinted area at least weekly to check the status of the skin.
- Factors to consider under these circumstances include:

  1) Whether the dressing/cast/splint is dry

  2) Whether there is a smell coming from the area underneath or around the dressing/cast/splint

  3) Whether the skin in the area of and around the dressing/cast/splint appears healthy. Whether there are any clinical signs which might be consistent with infection in the area of and around the dressing/cast/splint

  4) Whether there is any abnormality or condition which requires attention in the area of and around the dressing/cast/splint appears healthy.

  5) Changes in condition should be addressed by facility staff as provided for in this policy.

f. **Comprehensive skin review should occur on an "as needed" basis through the activity of the Interdisciplinary Team**

- The assessment/evaluation and recommendations of the IDT shall be documented in the resident's clinical record.

7. Communication of Changes

a. Any changes in the condition of the resident's skin as identified daily, weekly, monthly, or otherwise, must be communicated to :

- The resident/responsible party
- The resident's physician
- Others as necessary to facilitate healing

8. Response to Resident Choices That Differ From Plan of Care

a. If the resident is not able to or chooses not to participate in the care plan relative to prevention of skin breakdown, or treatment of existing wounds or skin breakdown, the nursing staff shall communicate with the resident's physician to discuss an appropriate intervention or response.

b. If the resident's physician is unavailable, the nursing staff shall contact the Medical Director.

9. Quality Assessment and Assurance

a. The Quality Assurance Committee should, among other things, evaluate strategies to reduce the development and progression of pressure ulcers as well as monitoring the incidence and prevalence of skin breakdown in the facility.

Regulatory Reference:

F686 Treatment/Services to Prevent/Heal Pressure Ulcers

References:

Centers for Medicare and Medicaid Services. (2017). *State operations manual appendix PP - Guidance to surveyors for long term care facilities.* https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

National Pressure Ulcer Advisory Panel (2017)
https://www.npuap.org/resources/educational-and-clinical-resources

10/14/2022

SKIN/PU AUDIT

RESIDENT'S NAME (RM.)	Admission Braden risk	Care Plan on PU/Mod to High risk Braden	Weekly wound progress /assesment current and	Documentation on new or worsening present	Communicatio n with MD or Family	Appropriate pressure relief order	Skin Committee meeting minutes	MDS "M" section Accurate	RD addresses skin,labs and increased needs	Unavoidable documentation(Not Scored)
								0	0	

Hillcrest Health Care
Policy/Procedure – Nursing Clinical

Section: **Licensed Nurse Procedures**

Subject: **Falls** **Policy Number: NCLN 55**

POLICY:

It is the policy of this facility to evaluate extent of injury after a fall and prevent complications.

PROCEDURES:

Equipment:

- Vital Sign equipment

1. Evaluate resident's condition before moving him.
2. Observe for bumps, bruises, cuts, abrasions, scrapes, body misalignment, confusion, level of consciousness.
3. Give Range of Motion (ROM) to extremities to assess for discomfort.
4. Do not stand resident upright; lift to bed or chair.
5. Cover to prevent chilling.
6. Notify physician.
7. Notify family or responsible party.
8. Initiate neuro checks for any fall where resident hit head or for any unwitnessed fall.
9. Observe for cause of the fall, e.g., wet floor, obstructed pathway.
10. Discard equipment or return it to the appropriate location.
11. Wash hands properly.
12. Document all appropriate information.

NOTE:
An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.

Hillcrest Health Care
Policy/Procedure

Section: **Quality of Care**

Subject: **Incidents and Accidents**

POLICY:

It is the policy of this facility to implement and maintain measures to avoid hazards and accidents. Should and accident/incident occur, the resident, staff member will be provided immediate attention by a licensed nurse, who will notify medical provider, family member, EMS, etc. as appropriate.

PROCEDURES:

1. Assisting Incident/Accident Victims:

   Any staff witnessing an accident/incident, or find it necessary to aid an accident victim (resident, staff), should:

A. Render immediate assistance. Do not move the victim until he/she has been examined for possible injuries;
B. If possible, move the injured to the treatment room, or if it is a resident in his/her room, move the resident to his or her bed; and
C. If assistance is needed, summon help. If you cannot leave the victim, ask someone to report to the nurses' station that help is needed, or if possible, use the call system located in the resident's room to summon help.

2. Licensed nurse will assess the resident (or visitor or staff), including vital signs, neuro checks if needed, complaints of pain and location, and determine if treatment or additional care is needed, including accessing the EMS system.
3. Licensed nurse will notify medical provider for residents, and obtain orders for further treatment or diagnosis as deemed necessary by the provider.

Hillcrest Health Care
Policy/Procedure – Nursing Clinical

Section: **Emergency Procedures**

Subject: **Neurological Evaluation**

POLICY:
It is the policy of this facility to gather accurate nursing data necessary for a comprehensive neurological assessment.

All incidents involving trauma to the head will result in a comprehensive neurological assessment for a minimum of seventy-two hours (72 hours.)

PROCEDURE:
A neurological assessment flowsheet will be utilized for all residents sustaining head trauma due to fall or other incidents.

POLICY:

It is the policy of this facility that neurological evaluation will be completed by a licensed nurse. The first examination of the resident is important to establish a baseline for future assessments. Any resident having an injury involving the head or an unobserved fall will have neuro checks and vital signs taken.

A comprehensive neurological assessment will be done as follows:

- Every 15 minutes x 4 (1 hour)
- Every 30 minutes x 4 (2 hours)
- Every 1 hour x 4 (4 hours)
- Every 4 hours x 4 (16 hours)
- Every 8 hours x 6 (48 hours)

1. Explain procedure to resident.
2. Obtain vital signs.
3. Assess Level of Consciousness:
    A. Oriented to person, place or thing.
    B. Drowsy.
    C. Stuporous: less responsive and in a sleeplike state. Not comparable to normal sleep from which a resident can be aroused for short intervals only.
    D. Comatose: Complete loss of consciousness from which the resident cannot be aroused.
4. Pupil Reaction and Eye Signs
5. Motor Ability.

Hillcrest Health Care
Policy/Procedure

Section: **Nursing Services**

Subject: **Sufficient Staff**

POLICY:

It is the policy of this facility to provide services by sufficient number on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being.

PROCEDURES:

1. The Director of Nursing services will be employed on a full-time basis

2. The Director of Nursing Services will serve for at least eight (8) consecutive hours a day,