DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165173	A. BUILDING _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE REHAB AND HEALTH CARE CENTER	830 SOUTH FIFTH STREET OSAGE, IA 50461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 06/20/2023 and 6/30/2023 The following deficiencies resulted from investigation of complaints #112189-C, # 112636-C, # 113094-C, #113445-C and facility reported incident #113018-I conducted May 23, 2023 to June 13, 2023. Complaints #112636-C and #113094-C, #113445-C were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	This plan of correction does not constitute an admission or agreement by Osage Rehabilitation & Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correct shall serve as Osage Rehabilitation & Health Care Center credible allegation of compliance.	
F 684 SS=D	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 observation, clinical record review, staff and resident interview, as well as facility policy review, at the time of the investigation, the facility failed to promptly identify and intervene for an unknown injury on a resident foot which had bruising on the left toe for 1 of 4 residents reviewed. (Resident #3). The facility identified a census of 38 residents.	F 684	F 684 1. Resident #3 was assessed by the licensed nurse on 6/8/23 and the physician was notified of the resident's current condition with no new orders noted. An incident investigation was completed by the DON on 6/30/23 for the bruise noted on Resident #3's foot with new interventions implemented. 2. Residents were assessed by a licensed nurse between 6/14/23 & 6/20/23 and the physician was notified if new injuries were identified. 3. Nurses were re-educated by Administrator/ Designee starting on or before 6/30/23 related to the process for injuries, including injuries of unknown source and notifications. 4. An audit will be completed by the DON or designee weekly for 12 weeks to ensure licensed nurses continue to address and notify physicians of any new injuries including injuries of unknown source. The results of these audits will be presented to the QAPI committee monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow-up as needed. Date of compliance 06/30/2023	06/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Fisher — TITLE: Administrator — (X6) DATE: 6/30/23

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 684	Continued From page 1 Findings include: An Admission Minimum Data Set (MDS) assessment form dated 4/12/23, documented Resident #3 had diagnoses that included Hypertension, diabetes mellitus, traumatic brain injury, bipolar disease, and schizophrenia. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 14 which indicated no memory problems and needing extensive assistance of two (2) staff members with bed mobility & dressing and total assistance of two (2) for transfers, toilet use, and bathing and a wheelchair as mobility device and no ambulation. The assessment also documented the resident with limitation to upper and lower extremity on one side for range of motion. A Care Plan with a focus area dated 4/24/23, documented the resident has potential/actual impairment to skin integrity. Interventions include the following: *Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. * Educate resident/family/caregivers of causative factors and measures to prevent skin injury. * Identify/document potential causative factors and eliminate/resolve where possible. * pressure relieving/reducing mattress, pillows to protect the skin while in bed. * pressure relieving cushion, pillows to protect the skin while up in chair. · Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration to the Medical Doctor. * BATHING: The resident requires, (2) staff participation with bathing for transfer, then one	F 684		

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F 684	Continued From page 2 assist for shower itself. A Weekly Skin Assessment dated 4/28/2023 at 3:21 p.m., documented, Bruised area to the top of the Left great toe that is light purple in color. Measures 2.0 cm by 3.2 cm. Resident states that area is tender. A Weekly Skin Assessment dated 5/4/2023 at 9:49 a.m., documented, Left toe(s) bruise on left big toe 2 centimeters (cm) x 2 cm. The Progress Notes lacked any documentation of the bruised area on top of the left great toe and no assessment or interventions were completed. Observation on 6/1/23 at 10:00 a.m., revealed no bruising on the top of the left great toe. Interview on 6/1/23 at 10:00 a.m., Resident #3, stated that while staff were pushing her down the carpeted hallway in a shower chair the left foot fell of the foot pedal and was dragged on the floor. Resident #3 told the Director of Nursing, the Director of Nursing looked at the left foot and there was a bruise on the top of the left great toe. Resident #3 explained that the area at the time did hurt but not any more. Interview on 6/5/23 at 10:00 a.m., the facility director of nursing stated that she investigated the area on top of the left great toe and that Resident #3 explained that the area on top of the left toe happened when staff where pushing the resident in a bath chair and the left foot slipped off the foot pad and left toe got caught under the shower chair. The DON confirmed and verified that the clinical record lacked any documentation of the assessment or any interventions for the left	F 684		

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F 684	Continued From page 3 great toe and no incident/accident or unusual occurrence forms were completed and it is an expectation that the facility staff follow the facility policy and procedure. The Incident/Accident Management Policy/Procedure dated 11/19, overview documented that all employees of the facility are responsible for reporting and identification of Incident/Accidents. The employee who witnesses or discovers the incident/accident will notify his/her supervisor to complete and Incident/Accident Report. Procedure: *Verify that the resident is evaluated for injury and if injury is suspected or present, that the appropriate first aid and /or outside medical intervention is provided. *Gather information related to the incident/accident. *Verify documentation is complete in the resident medical record. *Gather all statements, worksheets and any further information obtained during the course of the investigation.	F 684	F686 1. Resident #1 was discharged to the hospital on 5/24/23 2. Head to toe skin assessments will be completed between 06/14/23 and 06/20/23 by DON or designee to ensure pressure injuries have been identified and treatment plans implemented. Any areas of concern will be addressed at the time of the audit including a root cause analysis. An audit was completed by DONor designee on 06/20/23 to ensure preventive measures have been implemented for residents with pressure injuries or history/risk of pressure injuries. 3. The DON or designee will complete education with licensed nurses beginning 6/7/23 – 6/8/23 and again on 06/20/23 related to the	
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686	requirements of implementing interventions to reduce the risk for pressure injuries for any residents with current pressure injuries or history/risk of pressure injuries. The Administrator, Director of Nursing and MDS Nurse was educated on 06/20/23 by the VP of Clinical Services. Charge Nurses educated by Administrator/Designee on or before 6/26/23 related to completing root cause analysis on newly developed or worsening pressure injuries. The Director of Nursing and MDS nurse will be educated by the RDCS upon their return to work. A root cause analysis will be completed on newly identified or worsening pressure injuries to determine the appropriate interventions.	

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F 686	Continued From page 4 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, facility policy and procedure review, the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcers from developing and from deteriorating on a resident with a history of pressure ulcers for one of two residents reviewed (Resident #2). The facility failed to identify the root cause and implement appropriate interventions. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began April 13, 2023 on June 7, 2023 at 4:30 p.m. Facility staff removed the Immediate Jeopardy on June 8th, 2023 through the following actions: a. Head to toe assessments will be completed on 6/8/23 by the Regional Directors of Clinical Services (RDCS) or designee to ensure pressure injuries have been identified and treatment plans implemented. An audit was completed by the Regional Director of Clinical Services or designee to ensure preventive measures have been implemented for residents with pressure injuries or history/risk of pressure injuries. b. The RDCS or designee will complete education with licensed beginning 6/7/23-6/8/23 related to the requirements of implementation interventions to reduce the risk for pressure injuries for any residents with current pressure injuries or history/risk of pressure injuries.	F 686	4. An audit will be completed by the DON or designee weekly for 12 weeks to ensure licensed nurses continue to implement preventive measures for residents with pressure injuries or history/risk of pressure injuries. An audit will be completed by the RDCS weekly for 4 weeks and monthly for 2 months to ensure root cause analysis continues to be completed for newly developed or worsening pressure injuries. The results of these audits will be presented to the QAPI committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow-up as needed. Date of compliance: 06/20/2023	06/20/2023

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F 686	Continued From page 5 c. An audit will be completed by the Director of Nursing or designee weekly for 12 weeks to ensure licensed nurses continue to implement preventive measures for residents with pressure injuries or history/risk of pressure injuries. The results of these of these audits will be presented to the QAQI committee monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow-up as needed. The scope lowered from "J" to "D" at the time of the survey after ensuring the facility implemented education and their policy and procedure. The facility reported a census of 38 residents. Findings include: 1. An Admission Minimum Data Set (MDS) completed for Resident #2 with an Assessment Reference Date (ARD) of 3/12/23, documented diagnoses which included hypertension, neurogenic bladder, paraplegia, schizophrenia, and stage 2 pressure ulcers of sacral area. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no impaired cognitive decisions and no impairments for hearing or the ability to be understood and understand others. The resident required extensive assistance of one staff for dressing, toilet use, and personal hygiene and independent with bed mobility, transfers, and locomotion on and off the unit. The MDS also documented functional limitation in range of motion to lower extremities on both sides and a wheelchair as primary mode of transportation. The MDS also documented the resident admitted with 3 stage 2 pressure ulcers (partial thickness	F 686		

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F 686	Continued From page 6 of dermis presenting as a shallow open ulcer with a red or pink wound bed without slough) and pressure reducing device for chair & bed and pressure ulcer/injury care. The Braden scale for predicting pressure sores, dated 2/27/23 at 2:17 p.m., documented a score of 16, which indicated low risk for developing pressure ulcers. The Care Plan with a focus area initiated 2/27/23, indicated the resident had (3) pressure ulcer or potential for pressure ulcer development related to history of ulcers, immobility. Interventions include: *Administer treatments as ordered and monitor for effectiveness *(3/4/23) Stage 2 pressure ulcer times 3: coccyx every Monday, Wednesday, Saturday: cleanse with wound cleanser, place Aquacel Ag on wound base cover with sacral border, and as needed. *(3/4/23) Assess/record/monitor wound healing weekly, measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing process. Report improvements and declines to the Medical Doctor. *(4/20/23) Cushion in wheelchair *(3/4/23) Follow facility policies/protocols for the prevention/treatment of skin breakdown. A Medical/Nursing Communications form dated 4/1/23 at 9:46 p.m., documented, after bathing during a transfer from chair to bed resident obtained a 0.3 cm by 0.3 abrasion to right ischeum. No bleeding or pain. Bumped on wheelchair pedal per resident reports. After cleansing, border dressing placed for protection. Will change on bath days and as needed until	F 686		

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F 686	Continued From page 7 healed then will discontinue. The Non-Pressure Weekly Skin Record dated 4/2/23 at 10:47 a.m., documented, first observed on 4/1/23 a small bruise on right buttock. Measurements: 0.3 centimeters (cm) by 0.3 cm. A Physician Order dated 4/13/23, instructed staff to apply Mepilex to right hip reassure wound every day until healed. Monitor for signs of infection. Off load with position changes every 2 hours. A Nursing Home Progress Note dated 4/13/23 with no time, documented, nursing staff noticed a sore on his right hip. He has had a coccyxgeal sore that had been healing. He started to notice this area on his right hip and they did place a Mepilex on it last night. It has not had a lot of drainage. Denies any fevers or chills. *SKIN= Stage 2 pressure ulcer noted on the right hip. Measuring tool not available at time of evaluation but appears to be about 2 cm in diameter. No surrounding erythema or drainage. Mepilex placed back over the area. *PLAN= continue stage II pressure ulcer treatment with wound cleanser and Aquacel Ag in the wound base and then a sacral border every Monday, Wednesday, and Saturday until healed. Plan to do same cares to the Stage II pressure ulcer on the right hip. The Non-Pressure Weekly Skin Record dated 4/15/23 at 8:04 p.m., documented first observed on 4/15/23, a bruise to the right buttock, with the wound surface has a strong odor, measurements of 0.3 cm by 0.4 cm with no exudate, yes to odor, and progress as declining.	F 686		

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F 686	Continued From page 8 A Physicians Order dated 4/16/23 with no time, instructed staff to cleanse the wound with cleanser, and Aquacel Ag to wound base of right hip pressure ulcer along with Mepilex every Monday, Wednesday and Saturday until healed. A Wound Clinic Progress Note dated 4/20/23 at 10:53 a.m., documented, diagnosis= pressure ulcer of right hip. Patient paraplegic currently in a loaner wheelchair with a gel cushion. He is getting custom wheelchair cushion when he discharges home which is possibly next week. He self transfers and is up in a wheelchair most of the day. Location= right hip Stage=unstageable Size=3.2 cm by 4.0 cm by 0.2 cm Drainage color= serosangionous Drainage amount=large Drainage odor=moderate Wound base= 90% slough. 10% pink Wound Care= Recommend new evaluation for wheelchair cushion. Instructed patient to lay down between meals and limit time spent in wheelchair. Reposition off wound while in bed every 2 hours. A Non-Pressure Weekly Skin Record dated 4/22/23 at 3:33 p.m., documented first observed on 4/3/23, a right buttock pressure ulcer, with wound measurements as 4.0 cm by 4.0 cm by 3.0 cm. Exudate=yes Type of Exudate= serosanguinous; thin, watery, pale, red/pink drainage Amount of Exudate= moderate Odor=yes Tissue Type/Wound Bed= slough A Pressure Injury Weekly Assessment dated	F 686		

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F 686	Continued From page 9 4/26/23 at 3:42 p.m., documented pressure ulcer to right buttock which measures 3.0 cm by 4.0 cm by 2.5 cm as a Stage I. Exudate= serosanguinous, large amount Odor= present Wound bed appearance= slough A Pressure Injury Weekly Assessment dated 5/6/23 at 12:43 p.m., documented pressure ulcer to right buttock which measures 4.0 by 4.0 by 3.0-4.0 as a Stage III Exudate= serosanguinous, large amount of purulent drainage Odor=present Wound bed appearance= slough, necrotic tissue A Pressure Injury Weekly Assessment dated 5/13/23 at 8:45 p.m., documented pressure ulcer to right buttock which measures 5.0 cm by 3.0 cm by 3.0 cm, Stage IV. Exudate= purulent drainage, heavy amounts Odor=strong Wound bed appearance=necrotic Comments=current treatment is not effective, resident states he goes to see the wound doctor on Monday. A Wound Clinic Progress note dated 5/15/23 at 9:00 a.m., documented, patient is a paraplegic after falling off a ladder in October 2022, he has the wound for a month. Wound location= right buttock Wound Measurements= 3.5 cm by 4.5 cm by 4.9 cm Exudate=large Exudate type=purulent Wound odor=yes Slough=100% Assessment/Plan=Pressure injury of right	F 686		

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F 686	Continued From page 10 buttock. Stage 4. Patient presents today for initially treatment evaluation in this clinic of the pressure injury on the lateral right buttock near the trochanter. The wound is 100% necrotic with a foul odor. Patient does not recall noting an odor of bleach with the dressing changes. Patient has the appropriate wheelchair waiting for him when he is discharged form the nursing home. Apparently there is some rule that prevents the use of that chair in the facility. Explained to patient this is going to take along time to heal. Offloading= He will need a better wheelchair cushion, instructed to remain off of the right side while in bed as much as possible. Plan= This is a medical device related pressure injury from an old fitting wheelchair. A Wound Clinic Progress note dated 5/17/23, documented, chief complaint=pressure ulcer right hip, patient still in wheelchair from last week with no adjustments. Continue current treatment. Area worsened. Needs wheelchair adjustment or new wheelchair! A Pressure Injury Weekly Assessment dated 5/20/23 at 1:48 p.m., documented a pressure injury on the right buttock which measures 10.0 cm by 7.0 cm by 5.0 cm an unstageable. Exudate=purulent and copious amounts Odor=very strong Wound bed appearance=completely covered with slough and eschar Comments= current treatment does not seem effective and wound progressively getting worse A Wound Clinic Progress note dated 5/23/23 at 10:00 a.m., documented, this patient presents for wound assessment. Wound location=right buttock	F 686		

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F 686	Continued From page 11 Wound measurements=4.4 cm by 5.4 cm by 4.5 cm Exudate=large Exudate type=purulent Wound odor=yes Slough=100% Assessment/Plan= Patient presents for follow up of right buttock wound. He has not discharge from the rehabilitation facility yet. Tissue in the wound bed still consists of majority necrotic/slough. Discussed offloading/pressure relief, patient states he will try to remind himself to reposition more often. Discussed Emergency Room precautions. The Progress notes dated 3/23/23 at 11:49 a.m., documented, "coccyx resolved." discontinue treatment. Education provided on support surfaces, may need different wheelchair cushion, if area reoccurs such as a Roho cushion. He will need pressure relieving mattress if he doesn't already have one. He is able to move himself in bed and turns from side to side at night. He already knows to reposition chair, lifts while in wheelchair. The Progress notes dated 4/1/23 at 9:41 p.m., documented, after bathing during a transfer from chair to bed he obtained a 0.3 cm by 0.3 cm abrasion to right ischeum. No bleeding or pain. "Bumped on wheelchair pedal". he reports. After cleansing, bordered dressing placed for protection. Will change on bath days and as needed until healed then discontinue. The Progress notes dated 4/13/23 at 00:19 a.m., documented, Doctor notified of 2.6 cm by 0.7 cm open area to right ischeum with odor and drainage. I understand you will see him on rounds	F 686		

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F 686	Continued From page 12 today. Do you desire wound nurse to see him? The Progress notes dated 4/13/23 at 9:04 a.m., documented, received physician orders paper after doctor complete rounds. "Mepilex to right hip pressure wound every day until healed. monitor for signs of infection. Off load with position changes every 2 hours. The Progress notes dated 4/17/23 at 8:31 a.m., documented, received facsimile from doctor related to new physicians orders "wound cleanser and Aquacel Ag to wound base of right hip pressure ulcer along with Mepilex every Monday, Wednesday and Saturday until healed. The Progress notes dated 4/20/23 at 1:02 p.m., documented, resident saw wound nurse today. Wound nurse assessed right hip at this time and cleansed with wound cleanser and Aquacel Ag to wound base and covered with border foam. Wound nurse recommended we get new wheelchair cushion which we have gotten. Wound nurse instructed patient to lay down between meals and decrease time spent in wheelchair. Repositioning often. The Progress notes dated 4/22/2023 at 1:38 p.m., documented, Return fax, new orders received from Doctor. Cleanse with wound cleaner, apply Aquacel AG and cover with Mepilex on Monday, Wednesday, Friday. The Progress Notes dated 4/26/2023 at 3:52 p.m., Wound Care Nurse: Weekly Assessment Note Text: wound nurse here to see resident. orders to cleanse area with Normal Saline. apply 1/4 strength Dakins solution moistened gauze into wound base, cover with abdomen pad and	F 686		

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F 686	Continued From page 13 secure with tape. change 2 times a day and as needed. continue offloading area when in bed and laying down in between meals. will see again in 2 weeks The Progress notes dated 4/28/2023 at 3:18 p.m.,documented, Resident stated he is getting new custom wheel chair through insurance once he makes the move. Insurance will not cover custom chair until he moves out the facility The Progress notes dated 5/5/2023 at 4:59 a.m., documented,dressing change to left hip wound. Drainage purulent, strong order, necrotic wound bed,0.5 cm deep tunneling area normal surrounding wound color. Expressed concern to resident, wound nursing following. Will update DON in AM. Extensive time teaching the importance of off loading hip and mobilization. Verbalized understanding and was very receptive to teaching. The Progress notes dated 5/9/2023 at 00:18 a.m., documented, Continues with bactrim for treatment of skin concern right trochanter. No adverse reaction to antibiotic. Temperature 98.4. Good amount of fluid drank. Dressing is clean, dry, intact. The Progress notes dated 5/10/2023 10:30 p.m., documented. Continues with antibiotic to promote wound healing to right hip without adverse reaction. Wound nurse saw resident today; continue same treatment. M.D. updated. The Progress notes dated 5/11/2023 9:05 a.m., documented: seen by wound clinic on 5/10/23, progress note sent to doctor to review.	F 686		

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F 686	Continued From page 14 The Progress notes dated 5/13/2023 1:14 a.m., documented: Continues with antibiotic for right hip wound without adverse reaction. Decreased drainage of wound noted. Temperature 97.4. The Progress notes dated 5/13/2023 3:02 p.m., documented: Resident continue with antibiotic therapy for right hip wound. Resident with no adverse effects to medication at this time. Resident without s/s of increased infection and remains afebrile. The Progress notes dated 5/15/2023 2:37 a.m., documented: Resident remains on antibiotic treatment to promote wound healing. Will be ending May 19, 2023. No adverse effects noted from therapy thus far. Resident remains afebrile, free of pain, and off loading of right hip. Able to verbalize needs, no concerns at this time. The Progress notes dated 5/15/2023 at 12:24 p.m., documented: resident returned from his wound care appointment with new orders: "cleanse with Dakins and rinse with normal saline. then use Dakins soaked gauze roll for packing in the wound. secondary dressing is secured with tape. twice per day. it is important that half strength Dakins solution is used in this dressing change" The Progress notes dated 5/17/2023 3:00 p.m., documented: Wound nurse here today for pressure ulcer to right hip. Resident with measurements of 4.7 x 5.0 x 5.0 cm with Serosanguinous drainage of moderate large amount. Foul odor,undermining noted at 3 and 7 at 2.5. 10% of wound bed is pink with 90% black and slough tissue. peri wound intact and edge is well defined	F 686		

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F 686	Continued From page 15 The Progress notes dated 5/17/2023 at 3:07 p.m., documented: Orders to continue current treatment. Area worsened. Needs new wheel/ac or for his to be adjusted. Will be seen in 1 week if still facility. Has wound appointment set up with discharge. The Progress notes dated 5/23/2023 3:39 p.m., documented: Resident returned from wound appointment. Consultation form states to continue same wound care. Ensure packing is 1 whole piece and not multiple/separate pieces. Zinc oxide cream or skin barrier to surrounding skin to prevent breakdown. Periods of repositioning while in bed and in wheel/chair. Remind resident to reposition himself in the wheel/chair to relieve pressure. Interview on 5/24/23 at 3:05 p.m., the maintenance supervisor confirmed and verified that Resident #2 came into the facility with that wheelchair and that the black hard plastic piece is in the right place for an open area on the resident right hip and that the facility failed to intervene with an intervention to prevent a pressure ulcer from occurring. Interview on 5/24/23 at 9:05 a.m., Physical Therapy Assistant, confirmed and verified that Resident #2 came into the facility with that wheelchair and that the facility failed to do an evaluation on the recommendation from the Wound Clinic for a new pressure cushion and it is expected that staff follow through with that recommendation. In reviewing the wheelchair it is possible that the black hard plastic positioning device could be the culprit of the pressure ulcer and that it is expected that the staff notify the	F 686		

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F 686	Continued From page 16 therapy department of any new orders or evaluation for positioning. Interview on 5/24/23 at 2:05 p.m., Staff A, Certified Nursing Assistant (CNA), stated that Resident #2 would position themselves on the right side of the buttocks and would need to be reminded to position in the center of the wheelchair seat and keep the right hip off the hard black plastic piece on the right side of the wheelchair. Resident #2 would use a slide board and transfer from the bed to the wheelchair independently. Interview on 5/24/23 at 1:05 p.m., Staff B, Certified Medication Aide (CMA), stated that Resident #2 was independent with self transfer by the use of a slide board and would need reminded to center the buttock in the center of the wheelchair due to Resident #2 would position the right hip on the hard black plastic piece on the right side of the wheelchair. Interview on 5/24/23 at 1:30 p.m., Staff C, Licensed Practical Nurse (LPN), stated that Resident #2 would transfer from the bed to the wheelchair independently with the use of a slide board and would need reminded to position the buttock in the center of the wheelchair cushion to take the pressure off the right hip that would be positioned on the hard black plastic piece on the right side of the seat of the wheelchair. Interview on 5/25/23 at 12:05 p.m., Staff E, (Physician) confirmed and verified that the pressure ulcer on the right hip was a mechanical device pressure ulcer and that the pressure ulcer was avoidable if the facility would have followed the recommendation to look at the device in the	F 686		

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F 686	Continued From page 17 wheelchair that was causing the pressure ulcer. Interview on 5/30/23 at 5:05 p.m., Staff D, Registered Nurse (RN), stated that Resident #2 would transfer from the bed to the wheelchair independently with the use of a slide board and would not position in the center of the wheelchair cushion and would need to be reminded to keep off the right hip. It is the expectation of the facility staff to intervene and attempt different interventions to keep a pressure injury from developing. Interview on 5/31/23 at 2:20 p.m., the facility corporate quality assurance nurse confirmed and verified that it is the expectation of the facility staff to intervene with alternative interventions to keep a pressure injury from developing and implementing measures or interventions from deteriorating The Skin Care and Wound Management Treatment Protocol for Stage II Pressure Ulcer dated 9/11 documented: A Stage II pressure ulcer is defined as a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Procedure: *Obtain a physician order for treatment. Verify resident/patient has an order for pain medication. *Implement treatment protocol as ordered. *Document wound measurements and characteristics on the Skin Grid-Pressure no less than weekly. More frequent documentation may be indicated based on change in condition of wound. *Review effectiveness of treatment plan every 2 weeks and revise as needed.	F 686		

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F 686	Continued From page 18 The Skin Care and Wound Management Treatment Protocol for Stage III and IV Pressure Ulcer dated 6/15 documented: *A Stage III pressure ulcer is defined as a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. *A Stage IV pressure ulcer is defined as a full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Procedure: *Read and select the treatment protocol. Consider the type of wound, drainage, and depth when selecting the treatment options. *Obtain a physician order for treatment. *Implement treatment protocol as ordered. *Verify prevention interventions are in place. *Review effectiveness of treatment plan every 2 weeks and revise as needed.	F 686		