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
	165427	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWTON HEALTH CARE CENTER	200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208

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F 000	INITIAL COMMENTS	F 000		
✓	Correction date: 6/14/24			
ok/CP	The following deficiencies resulted from investigation of Complaints #120785-C, #120605-C and #120516-C and Facility Reported Incidents #120895-I conducted June 5th, 2024 to June 13, 2024. Complaint #120785-C was substantiated. Facility Reported Incident #120895-I was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interviews, the facility failed to follow professional standards of nursing care to make sure that treatments and dressings are being completed for 2 or 4 residents reviewed. (Resident #1 and Resident #8). The facility reported a census of 54 residents. Finding include: 1. The Admission Minimum Data Set (MDS) assessment dated 12/8/2023, revealed Resident #1 had diagnoses which included anemia, hip	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marion P | TITLE: administrator | (X6) DATE: 06/26/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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fracture, mood disorder, malnutrition and hypertension. The MDS documented the resident scored a 7 on the Brief Interview for Mental Status (BIMS). A score of 7 identified moderately impaired cognitive abilities. The MDS assessment documented the resident required dependent assistance with activities of daily living (toileting, personal hygiene, transfer, and bed mobility). The MDS documented that the resident had a stage 2 pressure ulcer.

The Plan of Care documented a problem area with initiated date of 12/23/2023 as a pressure ulcer, stage 2 with location of the coccyx. The interventions included the following;
-Weekly skin treatment documentation in accordance to wound nurse assessment and plan of care recommendations
-Treatment as ordered
-Encourage off loading by changing positions as in turning side to side

The Plan of Care with an initiated date 2/18/24, stated the resident had an open area to the right lower leg
Interventions included;
*Keep area dry
*Observe for signs/symptoms healing and notify physician of any changes
*Treatment as ordered.

The Medication Administration Record (MAR) and Treatment Record (TAR) for 12/1/23-12/31/23, instructed staff to:
*cleanse area, apply zinc-based moisture barrier two times a day for Stage 1 pressure wound to bilateral buttocks until resolved. not completed on 12/11/23 on days. (Start date of order was 12/9/23)

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F 658	Continued From page 2 *Clotrimazole cream 1%, apply to peri area topically two times a day for skin care until resolved then discontinue, not completed on 12/26/23 (Start date of order was 12/13/2023) *Triad wound paste dressing, apply to coccyx topically two times a day for wound care, not completed on 12/26/23. (Start date of order 12/23/2023) The Mar and Tar for 1/1/24-1/31/24, instructed staff to: *Administer Cephalexin 250 milligrams (mg) four times a day for 10 days (for a total of 40 doses), the resident only received 30 out of the 40 doses. (Start date 1/21/2024). *Cleanse wound to coccyx, pat dry, apply skin prep to skin surrounding wound, cover with border foam. Change every Monday, Wednesday and Friday for wound care, not completed on 1/17/24 *Cleanse wound to coccyx, pat dry, apply skin prep to skin surrounding wound. Cover with silicone super absorbent dressing. Change every day until resolved, one time a day for wound care, not completed on 1/25/24 *Right lower leg: clean with wound cleanser, apply triple antibiotic ointment, cover with abdominal pad and wrap with gauze roll, daily for wound healing, not completed on 1/29/24 *Triad hydrophilic cream, apply to affected area topically one time a day every Monday, Wednesday and Friday for skin moisture and redness, not completed on 1/17/24 and 1/19/24. *Triad hydrophilic cream, apply to coccyx topically one time a day for wound healing, not completed on 1/25/24 *Bacitracin ointment, apply to right leg sutures topically two times a day for wound care for 10 days, not completed on 1/25/24.	F 658		

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Nurses Note dated 1/22/24 at 4:49 a.m. documented the resident had remained on Keflex (Cephalexin) for wound to the right lower leg.

The Mar and TAR for 2/1/24-2/29/24, instructed staff to:
*Triad wound dressing, apply to right lower leg topically one time a day every Monday, Wednesday and Friday for wound healing, not completed on 2/16/24. (Start date 2/16/2024)
*Coccyx-cleanse with wound cleanser, dry thoroughly, apply collagen to wound bed and cover with foam bordered dressing, change three times a week, one time a day, not completed on 2/17/24. (Start date 2/11/2024)
*Dakins solution, apply to right lower leg, topically one time a day every Monday, Wednesday and Friday for wound healing, not completed on 2/16/24 and 2/21/24. (Start dated 2/16/2024)
*Right lower leg, clean with wound cleanser, apply triple antibiotic ointment, cover with abdominal pad and wrap with gauze roll daily, not completed on 2/5/24. (Start date 1/28/2024)

2. The Quarterly MDS Assessment dated 3/28/24, revealed Resident #8 had diagnoses which included anemia, hypertension, diabetes mellitus, pressure ulcer and chronic pain. The MDS documented the resident scored a 15 on the BIMS for which identified no impaired cognitive abilities, required substantial to dependent assist with activities of daily living.

The MAR and TAR for 4/1/24-4/30/24, instructed staff to:
*Left Buttocks: Cleanse area with Dakins quarter strength, apply calcium alginate to wound bed,

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cover with large SSA dressing. Change every day one time a day for wound healing, not completed on 4/15/24, 4/25/24, 4/27/24,4/28/24, 4/29/24
*Right buttocks: Cleanse area with wound cleanser, apply collagen sheet and secure with SSA dressing. Change every day one time a day for Wound healing, not completed on 4/15/24, 4/25/24, 4/28/24 and 4/29/24.

The MAR and TAR for 5/1/24-5/31/24, instructed staff to:
*Coccyx: Cleanse with quarter strength Dakins, apply collagen to open wound, and cover with a silicone super absorbent dressing.
Change daily and one time a day for wound care, not completed on 5/5/24, 5/30/24.
*Left Buttocks: Cleanse area with Dakins quarter strength, apply calcium alginate to wound bed, cover with large SSA dressing.
Change every day one time a day for wound healing, not completed on 5/5/24
*Left buttocks: Cleanse with quarter strength Dakins solution, apply collagen sheet to open wound bed, and cover with a LARGE silicone super absorbent dressing. Change daily, not completed on 5/30/24.

Interview on 6/10/24 at 4:22 p.m., the facility Director of Nursing and the facility Assistant Director of Nursing confirmed and verified that the staff are expected to complete the treatments as instructed on the MAR and TAR's and if the boxes were not checked, then the treatment was not completed.

The Policy and Procedure for Documentation of Wound Treatments dated 12/1/23, instructed staff to:
#3, Wound treatments are documented at the

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F 658	Continued From page 5 time of each treatment. If no treatment is due and indication on the status of the dressing shall be documented each shift.	F 658		
F 686 SS=G	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 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review, facility policy and procedure, the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcers from deteriorating on residents with history of pressure ulcers for two of four residents reviewed (Resident #1 and #8). The facility reported a census of 54 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony	F 686		

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prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

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

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

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

Unstageable Ulcer: inability to see the wound bed.

Other staging considerations include:
Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and 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.

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1. An Admission Minimum Data Set (MDS) completed for Resident #1 with an Assessment Reference Date (ARD) of 12/8/23, documented diagnosis for which included anemia, hypertension, hip fracture, malnutrition and unspecific mood disorder. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated moderately impaired cognitive decisions and no impairments for hearing or the ability to be understood and understand others and does not resist cares. The resident was dependent from staff for all activities of daily living, and dependent with transfers, and frequently incontinent of bladder and bowel. The MDS also documented a wheelchair/walker as prior mode of transportation. The MDS documented the resident with 1 stage 2 pressure ulcer and pressure reducing device for chair, bed and pressure ulcer/injury care and no turning or repositioning program.

The Braden scale for predicting pressure sores, dated 12/15/23, documented a score of 13 for which indicated moderately risk for skin breakdown. The mobility portion of the Braden scale documented that the resident is very limited, makes occasional though slight changes in body or extremity position, and is chair fast. Friction and Shear, problem, requires moderate to maximum assistance in moving, requires frequent repositioning with maximum assistance.

The Careplan with a focus area initiated 12/13/23, the resident had a pressure ulcer, Stage 2 on coccyx, present on admission. Interventions include:
*(12/13/23) air mattress

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F 686	Continued From page 8 *(12/13/23) Bradens quarterly and as needed *(2/18/24) Encourage off loading by hanging positions as in turning side to side *(1/17/24) leave brief open while in bed as resident allows *12/13/23) report signs of cellulitis (localized pain, redness, swelling, tenderness, drainage, fever) *(12/13/23) treatment as ordered *(12/13/23) Weekly skin/treatment documentation in accordance to wound nurse assessment and plan of care recommended. *(12/13/23) Wound clinic as ordered *(1/9/24) Utilize pressure reduction equipment and procedures as indicated for preventative: turn and reposition, cushion to wheelchair/recliner, specialty mattress to bed, roho-cushion An Admission/Readmission Narrative bundle with no date or time, documented: *bilateral buttock, pressure 13 by 13. suspected deep tissue injury. The Progress Notes dated 12/4/23 at 3:57 p.m., documented, Admission assessment, bilateral buttock: - Pressure: Length = 13, Width = 13, - Stage Suspected Deep Tissue Injury The Progress Notes dated 12/5/23 at 03:19 a.m., There are no open areas/skin issues at this time on assessment. The Progress Notes dated 12/6/23 at 2:25 p.m., Nurses Note Text: new fax received with order to refer to dietitian due to low protein and albumin. The Progress Notes dated 12/7/23 at 4:33 p.m., Nurses Note Text: Faxed request to Doctor for a wound/skin care consult for her skin issues. Will await fax return.	F 686		

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An Altered Skin Integrity Notification dated 12/8/23, documented Stage 1 pressure wound: bilateral buttocks, 13 by 13.

The Progress Notes dated 12/8/23 at 11:45 p.m., documented Nurses Note Text: Provider, acknowledged altered skin integrity notification related to new stage 1 pressure wound to bilateral buttocks. New order provided to treat utilizing facility's protocol for specified wound. TAR updated.

The Progress Notes dated 12/9/23 at 11:31 a,am., documented, Daily Skilled Charting pressure area to coccyx.

The Progress Notes dated 12/10/23 at 12:58 p.m., documented Nurses Note Text: This nurse assessed resident's buttock and applied treatment as ordered. Entire buttock red and irritated. Left upper buttock appears to have worsened, appears to be a stage II pressure ulcer. This nurse sent a fax to Primary Care Provider to make aware of findings. Awaiting a fax back. This nurse and a CNA was able to get resident to sit in her recliner for a little while to try to relieve some pressure on her buttock.

An Altered Skin Integrity Notification dated 12/10/23, documented Stage 2 pressure wound,
*left buttock-9 centimeters (cm) by 4 cm by 1 cm
*right buttock- 7 cm by 3 cm
*current treatment: cleanse area, apply zinc based barrier, still needed for bottom of buttocks area, red and irritated. upper left and right buttocks, left buttocks worsening, now Stage 2, new treatment needed. Can we get an order for an air mattress?

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A Weekly Pressure Wound Assessment dated 12/11/23, documented:
*How many wounds are present=1
*Sacrum-pressure- Stage 2

The Progress Notes dated 12/12/23 at 9:21 a.m., documented, Nurses Note Text: Received order from provider for resident to receive an air mattress, also would like a wound consult due to stage 2 area located on patients left buttock

The Progress Notes dated 12/13/23 at 11:45 a.m., documented, Nurses Note Text: This nurse called and spoke with Power Of Attorney (POA) regarding new treatment order Clotrimazole Cream 1% to affected area BID until healed then as needed. POA had no concerns. This nurse also spoke with him regarding wound consult, POA gave a verbal "ok" for resident to see the wound nurse.

The Progress Notes dated 12/14/23 at 11:11 p.m., documented, Nurses Note Text: altered skin integrity notification sheet returned for stage 2 to left buttocks and right buttocks signed per Primary Care Provider

The Progress Notes dated 12/18/23 at 10:00 a.m., documented, Nurses Note Text: Consent signed for Wound center with metro geriatrics by POA. faxed to Metro.

The Progress Notes dated 12/18/23 at 3:16 p.m., documented Daily Skilled Charting: There are no open areas/skin issues at this time on assessment.

The Progress Notes dated 12/19/23 at 00:38

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a.m., documented, Daily Skilled Charting. There are no open areas/skin issues at this time on assessment.

The Progress Notes dated 12/19/23 at 8:27 a.m., documented, Daily Skilled Charting Alterations in skin integrity are
noted Right hip surgical incision, area to coccyx.

Daily Skilled Charting A Metro-Geriatric Services, Wound Treatment Plan dated 12/22/23, documented: chief complaint= wound assessment-coccyx
*Skin inspection= coccyx- etiology, moisture, secondary= pressure
*Measurement= 3.5 cm by 5.1 cm by 0.2 cm,
*Wound Status= 20% granulation, 50% pink/red epithelial, 30% biofilm
*Exudates= moderate, thin, serous.
*Pain=3/10
*Orders and Requisitions:
Air mattress to bed, gel cushion to wheelchair/recliner
Turn side to side when in bed
Leave brief open when in bed

The Progress Notes dated 12/24/23 at 00:43 a.m., documented, Daily Skilled Charting Alterations in skin integrity are noted, Has significant moisture associated skin damage to coccyx extends to bilateral buttocks. Area reddened with pain during peri cares and during treatment..Resident irritable with nursing staff related to pain described as "burning" on coccyx. Writer unable to locate prescribed triad cream. House z-guard paste was applied.

The Progress Notes dated 12/24/23 at 11:48 a.m., documented Daily Skilled Charting: There

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are no open areas/skin issues at this time on assessment.

The Progress Notes dated 12/25/23 at 00:19 a.m., documented, Daily Skilled Charting Alterations in skin integrity are noted has moisture associated skin damage to coccyx with open area, utilizing prescribed treatments. reports pain to area while resting in bed on back. Continues to report pain to buttocks related to skin break down. Utilizing z-guard paste with cares and after incontinence episodes..

The Progress Notes dated 12/28/23 at 11:13 a.m., documented, Daily Skilled Charting: Alterations in skin integrity are noted has moisture associated skin damage to coccyx with open area treatment in place.

A Metro-Geriatric Services, Wound Treatment Plan dated 12/29/23, documented=chief complaint=wound assessment=coccyx
*Skin Inspection; Coccyx, etiology, moisture, secondary-pressure
*Measurement= 2.0 cm by 3.1 cm by 0.2 cm
*Wound Status= not healed, 20% granulation, 40% pink/red epithelia, 40% biofilm
*Exudates= moderate, thin, serous
*Pain=3/10
*Orders and Requisitions:
Continue air mattress to bed, gel cushion to wheelchair/recliner
Turn side to side when in bed
Leave brief open when in bed
Encourage off loading by changing positions every 2 hours

The Progress Notes dated 12/30/23 at 5:30 p.m., documented Nurses Note Text: Wound nurse

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	165427	A. BUILDING _____ B. WING _____	C 06/13/2024

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NEWTON HEALTH CARE CENTER	200 SOUTH EIGHTH AVENUE EAST NEWTON, IA 50208

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F 686	Continued From page 13	F 686		

here on 12-29-23 area to coccyx, moisture secondary to pressure, 2.0 x 3.1 x 0.2 cm not healed tissue is 20% granulation 40% pink and red epithelial 40% biofilm, wound bed is granulation tissue, moderate, thin serous exudate no odor pain 3/10
periwound is clean red epithelial tissue. new orders received to d/c current treatment and do Triad cream do not scrub off and apply bid and as needed, gently wipe away soiled areas and reapply paste to open area. orders updated and all parties notified.

The Progress Notes dated 12/30/23 at 10:41 p.m., documented, Daily Skilled Charting: Skin warm and dry and skin color is within normal limits. Skin turgor is normal. Mucous membranes are moist. There are no open areas/skin issues at this time on assessment.

The Progress Notes dated 12/31/23 at 11:35 a.m., documented, Nurses Note Text: No complaints up to this time. Bottom not as sore as it was yesterday. Triad ointment applied as ordered.

A Weekly Nursing Skin Assessment dated 1/4/24 at 2:20 a.m., documented:
*coccyx, treatment in place left side of coccyx
*coccyx, treatment in place right side of coccyx

A Metro-Geriatric Services, Wound Treatment Plan dated 1/5/24, documented=chief complaint=wound assessment=coccyx
*Skin Inspection; Coccyx, etiology, moisture, secondary-pressure
*Measurement= 1.2 cm by 1.3 cm by 0.2 cm
*Wound Status= not healed, 30% granulation, 40% pink/red epithelia, 30% biofilm

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F 686	Continued From page 14 *Exudate= moderate, thin, serous *Pain=3/10 *Orders and Requisitions: Continue air mattress to bed, gel cushion to wheelchair/recliner Turn side to side when in bed Leave brief open when in bed Encourage off loading by changing positions every 2 hours A Metro-Geriatric Services, Wound Treatment Plan dated 1/19/24, documented=chief complaint=wound assessment=coccyx *Skin Inspection; Coccyx, etiology, moisture, secondary-pressure *Measurement= 1.0 cm by 0.6 cm by 0.2 cm *Wound Status= not healed, 10% granulation, 40% pink/red epithelia, 50% biofilm *Exudate= moderate, thin, serous *Pain=3/10 *Orders and Requisitions: Continue air mattress to bed, gel cushion to wheelchair/recliner Turn side to side when in bed Leave brief open when in bed Encourage off loading by changing positions every 2-3 hours A Metro-Geriatric Services, Wound Treatment Plan dated 1/26/24, documented=chief complaint=wound assessment=coccyx *Skin Inspection; Coccyx, etiology, moisture, secondary-pressure *Measurement= 0.6 cm by 0.4 cm by 0.2 cm *Wound Status= not healed, 10% granulation, 40% pink/red epithelia, 50% biofilm *Exudate= small, thin, serous *Pain=3/10 *Orders and Requisitions:	F 686		

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F 686	Continued From page 15 Continue air mattress to bed, gel cushion to wheelchair/recliner Turn side to side when in bed Leave brief open when in bed Encourage off loading by changing positions every 2-3 hours A Weekly Nursing Skin Assessment dated 2/1/24 at 4:57 a.m., documented: *coccyx= wound treatment in place A Metro-Geriatric Services, Wound Treatment Plan dated 2/2/24, documented=chief complaint=wound assessment=coccyx *Skin Inspection; Coccyx, etiology, moisture, secondary-pressure *Measurement= 0.6 cm by 0.4 cm by 0.2 cm *Wound Status= not healed, 30% granulation, 40% pink/red epithelia, 30% biofilm *Exudate= moderate, thin, serous *Pain=4/10 *Orders and Requisitions: Continue air mattress to bed, gel cushion to wheelchair/recliner Turn side to side when in bed Leave brief open when in bed Encourage off loading by changing positions every 2-3 hours A Weekly Nursing Skin Assessment dated 2/5/24 at 1:52 a.m., documented: *coccyx= wound treatment in place A Metro-Geriatric Services, Wound Treatment Plan dated 2/9/24, documented=chief complaint=wound assessment=coccyx *Skin Inspection; Coccyx, etiology, moisture, secondary-pressure *Measurement= 0.8 cm by 0.4 cm by 0.2 cm	F 686		

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F 686	Continued From page 16 *Wound Status= not healed, 20% granulation, 40% pink/red epithelia, 40% biofilm *Exudate= moderate, thin, serous *Pain=4/10 *Orders and Requisitions: Continue air mattress to bed, gel cushion to wheelchair/recliner Turn side to side when in bed Leave brief open when in bed Encourage off loading by changing positions every 2-3 hours Nurses Note dated 2/6/24 at 5:14 a.m. documented no reports of wanting to die this nights, Tramadol given as scheduled resident did complain of pain with dressing change. Nurses Note 2/7/24 at 4:27 a.m. documented right lower leg pain scheduled Tramadol effective no reportes of wanting to die with increase of Trazadone (used to treat anxiety or depression). A Weekly Nursing Skin Assessment dated 2/11/24 at 00:32 a.m., documented: *coccyx= treatment in place A Metro-Geriatric Services, Wound Treatment Plan dated 2/16/24, documented=chief complaint=wound assessment=coccyx *Skin Inspection; Coccyx, etiology, moisture, secondary-pressure *Measurement= 0.8 cm by 0.3 cm by 0.2 cm *Wound Status= not healed, 30% granulation, 40% pink/red epithelia, 30% biofilm *Exudate= moderate, thin, serous *Pain=4/10 *Orders and Requisitions: Continue air mattress to bed, gel cushion to wheelchair/recliner	F 686		

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F 686	Continued From page 17 Turn side to side when in bed Encourage off loading by changing positions every 2-3 hours A Weekly Nursing Skin Assessment dated 2/19/24 at 00:33 a.m., documented: *coccyx= treatment in place A Metro-Geriatric Services, Wound Treatment Plan dated 2/23/24, documented=chief complaint=wound assessment=coccyx *Skin Inspection; Coccyx, etiology, moisture, secondary-pressure *Measurement= 0.6 cm by 0.3 cm by 0.2 cm *Wound Status= not healed, 20% granulation, 40% pink/red epithelia, 40% biofilm *Exudate= moderate, thin, serous *Pain=4/10 *Orders and Requisitions: Continue air mattress to bed, gel cushion to wheelchair/recliner Turn side to side when in bed Encourage off loading by changing positions every 2-3 hours Interview on 6/10/24 at 2:40 p.m., the facility Director of Nursing confirmed and verified that the clinical record lacked documentation of weekly skin measurements, and that it is the expectation of the nursing staff to follow the policy and procedures on wound documentation and assessments and that the clinical record lacked any documentation of the air mattress being applied to the bed upon admit. 2. A Re-entry MDS completed for Resident #8 documented return date of 2/17/24, from an acute care hospital.	F 686		

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A Quarterly MDS completed for Resident #8 with an ARD of 3/28/24, documented diagnosis for which included anemia, diabetes mellitus, pressure ulcer of sacral and buttock regions and chronic pain. The MDS documented the resident had a BIMS score of 15 which indicated no impaired cognitive decisions and no difficulty for hearing and is able to be understood and understand others and does not resist cares. The resident required dependence with all activities of daily living. The MDS also documented a wheelchair as prior mode of transportation. The MDS documented the resident with 2 stage 3 pressure ulcer, pressure reducing device for chair, bed and pressure ulcer/injury care and no turning or repositioning program.

The Braden scale for predicting pressure sores, dated 1/26/24, documented a score of 12, for which indicated high risk for pressure ulcers. The moisture portion of the Braden scale documented that the resident is very moist, skin is often but not always moist. Linen must be changed at least once a shift. The mobility portion of the Braden scale documented that the resident is very limited, makes occasional slight changes in body or extremity position but unable to make frequent or significant changes. Friction and Shear, problem, requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible

The Plan of Care with an initiated dated 3/3/24, stated the resident has actual impairment to skin integrity related to Stage 3 right and left buttocks. Interventions include:
*Complete Braden Scale every week x 4 following admission/readmission, then complete quarterly

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and as needed
*Follow facility protocols for treatment of injury.
*Keep skin clean and dry. Use lotion on dry skin.
*Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD.
*Turn and reposition during rounds and as needed.
*Utilizes a (pressure reducing/low air loss/etc) mattress
*Wound nurse consult as needed.

The Progress Notes dated 2/17/24 at 12:06 p.m., documented, Admission assessment: Abnormalities noted with skin assessment: sacral redness with tx in place. Skin is dry and flaky all over and tx with lotion in place.

A Weekly Nursing Skin Assessment dated 2/17/24 at 1:39 p.m., documented a sacrum wound, treatment in place, no size or description of the area.

A Weekly Nursing Skin Assessment dated 2/21/23 at 6:42 p.m., documented a sacrum wound, treatment in place, no size or description of the area.

A Weekly Nursing Skin Assessment dated 3/1/24 at 1:36 a.m., documented a sacrum wound, treatment in place, no size or description of the wound.

The Progress Notes dated 3/9/24 at 3:47 a.m., documented, Nurses Note Text: Resident Peri wound warm dry and
intact.

A Weekly Nursing Skin Assessment dated

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3/13/24 at 4:10 a.m., documented a sacrum wound, treatment in place, no size or description of the wound.

The Progress Notes dated 3/15/24 at 8:09 a.m., documented Nurses Note Text: During hour of sleep treatments,
resident coccyx/sacrum starting to break down. Area is superficial. Area has some bleeding noted, with small amount of granulation tissue observed. Noted resident does have decrease in adipose tissue to area. Reported to this nurse,resident does not like to get up in wheel chair. When asked about getting up she stated "it hurts too much"

A Weekly Nursing Skin Assessment dated 3/15/24 at 1:35 p.m., documented an alteration in skin integrity with coccyx wound 3 cm by 1.5 cm, right buttock 3.5 cm by 1.7 cm and left buttock, 5 cm by 2.5 cm., these areas are new for this resident.

An Skin/skin tear/abrasion/burn/bruise report dated 3/15/24 at 2:56 a.m., documented, during hour of sleep treatments, resident coccyx/sacrum starting to breakdown. Area is superficial. Area has some bleeding noted, with small amount of granulation tissue observed. Noted resident does have decrease in adipose tissue to area. Area cleansed and covered for protection.

A Metro-Geriatric Services, Wound Treatment Plan dated 3/22/24, documented=chief complaint=wound assessment=buttocks/sacrum
*Skin Inspection; left buttocks, pressure, Stage 3,
*Measurement= 8.0 cm by 4.3 cm by 0.2 cm, very scattered
*Wound Status= new tissue, 60% pink/red

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F 686	Continued From page 21 epithelia, 30% granulation, 10% biofilm *Exudate= moderate, thin, sanguineous *Skin Inspection: right buttocks, pressure Stage 3 *Measurement=3.4 cm by 5.1 cm by 0.2 cm, scattered *Wound Status= new tissue, 70% pink/epithelia, 30% granulation *Orders and Requisitions: Continue air mattress Roho or equalgel cushion to wheelchair/and recliner Strict turning schedule when in bed A Metro-Geriatric Services, Wound Treatment Plan dated 3/29/24, documented=chief complaint=wound assessment=buttocks/sacrum *Skin Inspection; left buttocks, pressure, Stage 3, *Measurement= 7.0 cm by 3.6 cm by 0.2 cm, very scattered *Wound Status= new tissue, not healed, 50% pink/red epithelia, 40% granulation, 10% biofilm *Exudate= moderate, thin, sanguineous *Pain=4/10 *Skin Inspection: right buttocks, pressure Stage 3 *Measurement=0.4 cm by 0.5 cm by 0.2 cm, scattered *Wound Status= new tissue, not healed, 30% pink/epithelia, 50% granulation, 20% biofilm *Pain=3/10 *Orders and Requisitions: Continue air mattress Roho or equalgel cushion to wheelchair/and recliner Strict turning schedule when in bed A Metro-Geriatric Services, Wound Treatment Plan dated 4/5/24, documented=chief complaint=wound assessment=buttocks/sacrum *Skin Inspection; left buttocks, pressure, Stage 3,	F 686		

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F 686	Continued From page 22 *Measurement= 6.0 cm by 4.5 cm by 0.2 cm, very scattered *Wound Status= not healed, 30% pink/red epithelia, 60% granulation, 10% biofilm *Exudate= moderate, thin, sanguineous *Pain=4/10 *Skin Inspection: right buttocks, pressure Stage 3 *Measurement=2.2 cm by 0.9 cm by 0.2 cm, scattered *Wound Status= new tissue, not healed, 30% pink/epithelia, 60% granulation, 10% biofilm *Pain=3/10 *Orders and Requisitions: Strict turning schedule when in bed A Metro-Geriatric Services, Wound Treatment Plan dated 4/19/24, documented=chief complaint=wound assessment=buttocks/sacrum *Skin Inspection; left buttocks, pressure, Stage 3, *Measurement= 6.3 cm by 3.2 cm by 0.2 cm, very scattered *Wound Status= not healed, 30% pink/red epithelia, 40% granulation, 30% biofilm *Exudate= moderate, thin, sanguineous *Pain=4/10 *Skin Inspection: right buttocks, pressure Stage 3 *Measurement=0.9 cm by 0.6 cm by 0.2 cm, scattered *Wound Status= new tissue, not healed, 30% pink/epithelia, 50% granulation, 20% biofilm *Pain=3/10 *Orders and Requisitions: Strict turning schedule when in bed A Metro-Geriatric Services, Wound Treatment Plan dated 4/26/24, documented=chief complaint=wound assessment=buttocks/sacrum *Skin Inspection; left buttocks, pressure, Stage 3,	F 686		

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*Measurement= 10.3 cm by 3.1 cm by 0.2 cm, very scattered
*Wound Status= not healed, 50% pink/red epithelia, 30% granulation, 20% biofilm
*Exudate= moderate, thin, sanguineous
*Pain=4/10
*Skin Inspection: right buttocks, pressure Stage 3
*Measurement=0.6 cm by 0.3 cm by 0.2 cm, scattered
*Wound Status= new tissue, not healed, 30% pink/epithelia, 50% granulation, 20% biofilm
*Pain=3/10
*Orders and Requisitions:
Strict turning schedule when in bed

A Weekly Nursing Skin Assessment dated 4/26/24 at 4:28 a.m., documented, right and left buttock, stage 3 pressure ulcers, no size or description of ulcers.

A Metro-Geriatric Services, Wound Treatment Plan dated 5/3/24, documented=chief complaint=wound assessment=buttocks/sacrum
*Skin Inspection; left buttocks, pressure, Stage 3,
*Measurement= 9.8 cm by 2.9 cm by 0.2 cm, very scattered
*Wound Status= not healed, 50% pink/red epithelia, 40% granulation, 10% biofilm
*Exudate= moderate, thin, sanguineous
*Pain=4/10
*Skin Inspection: right buttocks, pressure Stage 3
*Measurement=0.7 cm by 0.3 cm by 0.2 cm, scattered
*Wound Status= new tissue, not healed, 30% pink/epithelia, 70% granulation,
*Pain=3/10
*Orders and Requisitions:
Strict turning schedule when in bed

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A Weekly Pressure Wound Assessment dated 5/3/24 at 1:32 p.m., documented, right buttock pressure area, 0.7 cm by 0.3 cm by 0.2 cm Stage 3. left buttock pressure area, 9.8 cm by 2.9 cm by 0.2 cm Stage 3.

A Metro-Geriatric Services, Wound Treatment Plan dated 5/10/24, documented=chief complaint=wound assessment=buttocks/sacrum
*Skin Inspection; left buttocks, pressure, Stage 3,
*Measurement= 9.2 cm by 2.5 cm by 0.2 cm, very scattered
*Wound Status= not healed, 50% pink/red epithelia, 40% granulation, 10% biofilm
*Exudate= moderate, thin, sanguineous
*Pain=4/10
*Skin Inspection: right buttocks, pressure Stage 3
*Measurement=0.0 cm by 0.0 cm by 0.0 cm, scattered
*Wound Status= resurfaced, 100% pink/epithelial
*Pain=0/10
*Orders and Requisitions:
Strict turning schedule when in bed

A Metro-Geriatric Services, Wound Treatment Plan dated 5/10/24, documented=chief complaint=wound assessment=buttocks/sacrum
*Skin Inspection; left buttocks, pressure, Stage 3,
*Measurement= 0.2 cm by 0.2 cm by 0.2 cm, very scattered
*Wound Status= not healed, 30% pink/red epithelial, 60% granulation, 10% biofilm
*Exudate= moderate, thin, sanguineous
*Orders and Requisitions:
Strict turning schedule when in bed

The Progress Notes dated 5/17/24 at 9:02 a.m., documented, resident seen by wound nurse today, area to upper left buttock near coccyx is

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0.2 cm by 0.2 cm by 0.1 cm, all other areas to buttock healed and will continue to look at next week on wound rounds to ensure areas remain closed.

A Metro-Geriatric Services, Wound Treatment Plan dated 5/24/24, documented=chief complaint=wound assessment=buttocks/sacrum
*Skin Inspection; left buttocks, pressure, Stage 3,
*Measurement= 0.4 cm by 0.7 cm by 0.2 cm, very scattered
*Wound Status= not healed, 30% pink/red epithelial, 60% granulation, 10% biofilm
*Exudate= moderate, thin, sanguineous
*Skin Inspection; coccyx, pressure Stage 3,
*Measurement= 4.1 cm by 2.4 cm by 0.2 cm
*Orders and Requisitions:
Strict turning schedule when in bed

A Metro-Geriatric Services, Wound Treatment Plan dated 6/7/24, documented=chief complaint=wound assessment=buttocks/sacrum
*Skin Inspection; left buttocks, pressure, Stage 3,
*Measurement= 0.4 cm by 0.5 cm by 0.2 cm, very scattered
*Wound Status= not healed, 40% pink/red epithelial, 20% granulation, 10% biofilm, 30% partial thickness
*Exudate= moderate, thin, sanguineous
*Skin Inspection; coccyx, pressure Stage 3,
*Measurement= 0 cm by 0 cm by 0 cm
*Orders and Requisitions:
Strict turning schedule when in bed

Observation on 6/5/24 at 4:20 p.m., resident was lying in bed on an air mattress on her back, no wheelchair or recliner in the room.

Observation on 6/6/24 at 10:00 a.m. resident lying

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in bed on an air mattress with blue bolsters on right side of her shoulders, resident stated that staff don't reposition her as often as she would like, sometimes it will be an extended long period of time, at least over 2 hours before they come in to reposition her.

Interview on 6/11/24 at 10:00 a.m., the facility DON and ADON, both confirmed and verified that the clinical record lacked any documentation of a strict turning schedule, and that the expectation of a strict turning schedule would be at least every 1 hour.

The Policy/Procedure for Documentation of Wound Treatments with a implemented date 12/1/23, stated that the policy of the facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, an d changes in treatment.
1. Wound assessments are documented upon admission, weekly and as needed if the resident or wound condition deteriorates.
2. The following elements are documented as part of a complete wound assessment:
a. Type of wound, and anatomical location
b. Stage of the wound, if pressure injury (stage 1,2,3,4, deep tissue pressure injury, unstageable pressure injury) or the degree of skin loss if non-pressure.
c. Measurements: height, width, depth, undermining, tunneling
d. Description of the wound characteristics:
*color of the wound bed
*type of tissue in the wound bed
*condition of the peri wound skin
*Presence, amount and characteristics of wound drainage/exudate

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F 686	Continued From page 27 *Presence of absence of odor or pain A General Chart Documentation Guidelines with no dated, instructed staff to: *Wound documentation-weekly wound notes with measurements/wound characteristics, changes in wound status, unavoidable wounds, treatments used or changed, practitioner/family notification/updates	F 686		
F 689 SS=D	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 observations, clinical record review, staff interviews and facility policy review the facility failed to provide adequate supervision to ensure residents remained safe from Resident #4 who had verbal and physical altercations on 3/3/24 with (Resident #6), and 5/11/24 with (Resident #3). The facility reported a census of 54 residents. 1. The Quarterly Minimum Data Set (MDS) assessment dated 4/4/24, documented diagnosis for Resident #4 which included hypertension, insomnia and depression. The MDS documented the resident with a Brief Interview for Mental Status (BIMS) score of 9 for which indicated moderately impaired decision making abilities.	F 689		

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The MDS documented the resident as able to be understood and the ability to understand. The MDS documented Resident #4 with no physical or verbal behavioral symptoms directed towards others and no wandering for which affects others. Resident #4 required partial to moderate assistance with transfers and ambulation.

The Care Plan with an initiated date 4/4/24, revealed a focus area of I have episodes of behaviors/potential for behaviors as evidenced by becoming verbally agitated at times when feels that staff are not listening and was the aggressor in a resident to resident physical altercation. Interventions include:
*(5/13/24) 1-1 social services visits weekly and as needed.
*(4/4/24) Anticipate and meet the resident needs
*(5/13/24) care conference to be scheduled, supervision during meals and activities, will give more space as resident gets upset continues to decline. Medication review has been completed. Resident has been moved to 15 minute checks. The checks were successful. Moved to hourly checks.
*(4/4/24) Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her passing by
*(5/10/24) Resident moved to another room.
*(5/10/24) Resident put on one on one supervision for physical aggression with roommate.
*(4/4/24) If reasonable, discuss the resident behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.
*(4/4/24) Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.

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*(4/4/24) Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situation. Document behavior and potential caused.
*(5/13/24) Staff will offer music to help calm.

Observation on 6/6/24 at 11:10 a.m., revealed Resident #4 sitting in a wheelchair in room with television on and blinds to outside open. Resident #4 stated that Resident #3 over the bedside table was in the way to the bathroom and that Resident #3 stated to not touch the table and Resident #4 got upset and went over and started to hit Resident #3.

The Progress notes documented on the following dates and times:
*3/3/24 at 3:06 p.m., Resident has been agitated on and off throughout day, resident is in hub and is screaming wanting medications when ever he wants his medications not when they are ordered. Resident said "If I get bad enough and cause problems and hit people and yell and scream will you call the cops and they can take me away and give me my medications when I want them." This nurse educated resident but he refused to listen to this nurse and became angry again. Resident has had several more verbal outbursts during day. Resident is unable top be redirected. Staff have attempted to calm resident down and resident continues to scream at staff. Resident refuses to lay down stating "I cant, Can't sleep anymore."
*4/25/2024 at 1:10 p.m., Behavior Note; Note Text: Social Service Designee observed resident yelling profanities at another female resident who was taking too long to pass in her wheelchair. Resident calmed down and was redirected.
*5/11/2024 at 5:01 a.m., Nurses Note; Note Text:

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This nurse was passing medication to other resident's when
I heard "help" Certified Nursing Assistant (CNA) staff arrived before this nurse did and separated residents immediately. Reported to this nurse resident was striking another resident. Increase agitation noted. Resident had to be redirected numerous times for him to leave the area. Vitals taken and within normal limits. No injuries noted. Resident was moved to another room, family, on call provider called.
*5/11/2024 at 2:44 p.m., Nurses Note Text: resident was in the hub at meal time yelling cursing and threatening aggression raising his fists hub was cleared on resident and this nurse and CNA stayed with resident until I was able to calm him down after talking at great lengthy and explaining of the need to keep himself and other resident s safe. resident is upset over 1:1 feeling like he is being babysat all the time and 1:1 is causing much increased frustrations on the resident part. resident threatening to hit other residents and raising fists. this nurse attempted to remove resident from hub. resident was resistive stating he shouldn't be kept in prison. resident was laughing and joking after conversation with this nurse no longer threatening staff and other residents.
*5/11/2024 at 10:42 p.m., Nurses Note Text: 1:1 continues with resident remaining in his room throughout the night. No attempts to approach or speak to Resident #3. Pleasant and cooperative.
*5/13/2024 at 11:16 a.m., Social Services Note Text: Social Service Designee and Assistant Director of Nursing (ADON) met with resident in his room. Resident voiced understanding that hitting another was very serious and can never happen again. He laughed and showed no remorse for his actions. Resident stated that he

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has been in jail before so being on 1:1 is no different to him. It was made clear that he needs to stay away from the other resident that he hit and cannot go down hall 3.
*5/13/2024 at 11:46 p.m., Nurses Note Text: Resident continues on 15 minute checks, is one one one with meals and activities. Resident attempted to go down hall 300 x 1 to go visit another resident. Staff explained to resident of the rules. Resident became agitated but quickly calmed down when other activities were offered. Resident to bed.
*5/14/2024 at 10:43 a.m., Social Services Note Text: Social Service Designee had 1:1 with resident. When asked why he went down hall 3 when he was told that it wasn't allowed, he replied that he thought it was just for yesterday. Clarified with him that is until further notice. He voiced understanding that if he wants to talk to his friend on hall 3, they can do it in other parts of the facility.
*5/16/2024 at 8:25 a.m., Social Services Note Text: Social Serviced Designee had 1:1 with resident. Resident stated that when he see Resident #3 he just goes the other way. He still is not sorry that he struck him and thinks it was Resident #3 fault for making him mad.

Review of the Incident Report dated 5/10/24 at 10:42 p.m., This nurse was passing medication to other residents when I heard "help" CNA staff arrived before this nurse. Reported to this nurse resident was striking another resident. Residents separated, call placed to family member, left message for on-call provider. Resident put on one on one, will request for medication review and labs from regular provider next week. Resident with agitated/anxious and combative and dislikes roommate.

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Review of the 5-day Investigation of Resident-to-Resident dated 5/10/24 at 8:45 p.m., documented that on 5/10/24 at 8:45 p.m., staff member heard Resident #3 yelling out from his room, CNA entered the room and observed Resident #4 grabbing Resident #3 wrist and hitting Resident #3 on the side of the face. Residents were immediately separated. Complete head-to-toe assessments on both residents. Resident #4 had no injuries. Resident #3 had redness to the left side of nose and cheek, redness to right arm and scratch to left hand. Administrator, family, physician notified. Resident #4 was moved to a private room on a separate hallway. Our investigation has concluded that Resident #4 became agitated when attempting to go to the bathroom and Resident #3 bedside table was in the way. Resident #4 then began kicking the bedside table. Resident #3 requested for Resident #4 to stop touching his belongings. Resident #4 became upset with Resident #3 and the incident occurred. A care conference was held with Resident #4 to review the incident. Alternative coping mechanisms were discussed, and the care plan reviewed and updated with interventions specific to Resident #4 needs. Interventions include offering music, 1-1 social service visit weekly and as needed, 1-1 supervision during meals and activities until reviewed. Resident visited 1-1 with social services and will continue 2 times per week for a month. Resident #4 has no prior history of resident-to-resident incidents or physical aggression. Resident #4 demonstrates impaired ability to cope with stressors, was relocated to a private room on an alternative hallway to prevent further incidents, will benefit from remaining in a private room until further reviews, will receive

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increased support and assistance with redirecting during times of agitation, staff will work with to develop coping mechanisms such a activity diversion, 1-1 emotional support visits with assist with learning alternative means of coping with agitation.

2. The MDS assessment dated 4/4/24, documented diagnosis for Resident #6 which included hypertension, hypertension, mild cognitive impairment and muscle weakness. The MDS documented the resident with a BIMS score of 14 for which indicated no impaired decision making abilities. Resident #6 required dependent assist with transfers and a wheelchair used for mobility. The MDS documented the resident as able to be understood and is able to understand.

The Care Plan with an initiated date 4/3/24, revealed a focus area, resident is at risk for yelling out and verbal combativeness during cares due to cognitive impairment and pain at times. At times can also make rude comments to roommate or peers. Interventions include:
*Administer medications as ordered. Monitor/document for side effects and effectiveness.
*Attempt nonpharmacological interventions before using PRN medications.
*IDT team to review resident in Behavior Management Meeting quarterly or as needs arise.
*Intervene as necessary to protect the rights and safety of the other residents.
*Approach/ speak in a clam manner, Divert attention if needed. Remove from the situation and take to alternate location as needed.
*Minimize the potential for the residents disruptive behaviors by explaining cares, administering pain medications as ordered, empathizing with

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resident during cares.
*Observe and chart behaviors as necessary and report to physician.
*Observe for early warning signs of oncoming behaviors- Approach in a call manner, call by name, remove from unwanted stimuli.

3. The MDS assessment dated 5/9/24, documented diagnosis for Resident #3 which included hypertension, left hip fracture and cognitive communication deficit. The MDS documented the resident with a BIMS score of 11 for which indicates moderately decision making abilities and has difficulty with communicating some words or thoughts and is partial to moderate assistance with transfers and a wheelchair is the primary mode of transportation.

The Care Plan with an initiated date 2/9/24, and a revision date 5/17/24, Resident was on the receiving end of a resident on resident incident on 5/10/24, resident denies emotional effects from the incident. Interventions include:
*Allow resident to express concerns related to incident with management staff as needed.

The Progress notes documented on the following dates and times:
*5/11/2024 at 4:59 a.m., Nurses Note Text: This nurse was passing medication to other resident's when I heard "help" CNA staff arrived before this nurse did and separated residents immediately. Residents separated, room
mate moved to another room, family, on call provider called. Resident assessed for injuries, neuro's continue from previous fall in the day.
*5/12/2024 at 10:45 a.m., Nurses Note Text: F/U altercation with room mate on 5/10/24, Remains alert to verbal et physical stimuli. Verbally

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responds in conversation with responses generally appropriate to question and/or conversation. Mental status unchanged from baseline. No noted or reported emotional affects from negative
interaction from peer. No further attempts to approach or speak to Resident #4. Denied any concerns or complaints
*5/12/2024 at 1:39 p.m., Nurses Note Text: Resident in good mood today, no signs of injury or emotional distress noted from altercation with another resident 2 days prior.
*5/13/2024 at 1:07 p.m., Social Service Note Text: Social Service Designee had 1:1 with resident after therapy reported that Resident #3 stated that he was looking for the resident that hit him to pay him back. Resident voiced understanding that there would be serious consequences if he were to retaliate. He said that it is over as far as he is concerned but he will defend himself if he comes at him again. He will not go looking for him.
*5/13/2024 at 2:45 p.m., Nurses Note Text: No injuries noted from altercation with other resident. No increased behaviors. No complaints voiced. No other concerns at this time.
*5/14/2024 at 10:53 a.m., Social Service Note Text: SSD had 1:1 with resident in his room. He was glad that his roommate's things were moved out. He reports that he is doing fine and is having no thoughts about retaliation. He
denies any lasting emotional effect from being stuck by his previous roommate.
*5/14/2024 at 3:54 p.m., Nurses Note Text: No injuries noted from altercation with other resident. No increased behaviors. No complaints voiced. No other concerns at this time.

The Incident Report dated 5/10/24 at 8:42 p.m.,

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documented, This nurse was passing medication to other resident when I heard "help" CNA staff arrived before this nurse did and separated resident immediately. Resident #3 states that his room mate bumped into his bedside table and resident told roommate that we do no do that to other peoples things, Resident stated that his roommate started kicking the bedside table and knocked belongings from bedside table off onto the floor and sent the stuff flying. Resident stated that he told the roommate that he was going to pay for that and that is when roommate came up and started hitting him and resident blocked the first hit and then roommate started hitting him in the head. Resident separated, roommate moved to another room. Abrasion on face, bruise right forehead, and abrasion on right forehead. Resident has abrasions to right chin 1 centimeter (cm) by 1 cm, and left side 1 cm by 2 cm, bruising to right side of forehead by hair line, area is faint approximately 3 cm by 3 cm, superficial scratch to right eye lid an and 0.1 cm by 0.2 cm area cleansed and left open to air. Laceration to left wrist 0.1 cm by 1.0 cm , area cleansed and steri stripped and covered.

Interview on 6/10/24 at 2:30 p.m., the facility Director of Nursing and the Assistant Director of Nursing, confirmed and verified that Resident #4 needed increase in supervision due to the fact that there was an incident on 4/25/24 and there was an entry in the progress notes from 3/3/24, that the resident was going to hit someone and it is the expectation of the staff to keep all resident safe.

Interview on 6/10/24 at 3:15 p.m., the facility Administrator confirmed and verified that Resident #4 needed more supervision due to the

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F 689	Continued From page 37 fact that there have been resident to resident altercations with other residents and it is the facility responsibility to keep residents supervised and safe. The Resident Rights Policy and Procedure with no date, documented: Freedom from Abuse and Neglect: Residents have the right to be free from verbal, sexual, physical and mental abuse and involuntary seclusions by anyone including, but not limited to Provider staff, other Residents, consultants, volunteers, and staff from other agencies, family members or other individuals.	F 689		

Plan of Correction for Newton Health Care Center-Provider #165427

Date of Investigation: June 5-13th, 2024

Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F-658 Services Provided Meet Professional Standards

- The facility does follow professional standards of the nursing care to make sure the treatments and dressings are being completed.

- Resident #1 no longer resides at the facility.

- Resident #8's skin was assessed on 6.12.24 and followed by the wound provider.

-Education provided to nurses on 6/10/2024 related to Weekly Skin Assessments, New Skin Concerns, Documentation including measurements and treatments completed as ordered.

- Skin sweep completed on all residents on 6/12/2024.

- Wound provider thru Metro Geriatrics has been designated to manage wound care and treatments and advise facility on treatments ongoing for all significant and non-healing wounds 6/12/2024.

-DON/ADON/Designee will audit to ensure all wound assessments are being completed and documented with measurements, treatments completed as ordered, and interventions are on care plan and followed daily on weekdays times 1 week, 3 times weekly for 2 weeks, 2 times weekly for 2 weeks and weekly for 4 months.

- Results will be discussed at the following QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 6/14/2024

F-686 Treatment/Services to Prevent/Heal Pressure Ulcer

- The facility does provide care consistent with professional standards of practice to prevent pressure ulcers from deteriorating on residents with history of pressure ulcers.

- Resident #1 no longer resides at the facility.

- Resident #8's skin was assessed on 6.12.24 with wound measurements and documentation and will continue to measure weekly going forward.

- Education provided to nurses, CMA's and CNA's by DON regarding completing skin/wound treatments as ordered by the physician on 6/12/2024. Additional Wound Care Inservice was held with Gentell on 6.20.24 at 1:30 pm.

- Education provided to nurses on 6/10/2024 related to Weekly Skin Assessments, New Skin Concerns, Documentation including measurements and treatments completed as ordered.

- Skin sweep completed on all residents completed on 6.12.24. All residents with wounds have been assessed, measured, and documented on 6.12.24.

- DON/ADON/Designee will audit to ensure all wound assessments are being completed and documented with measurements, treatments completed as ordered, and interventions are on care plan and followed daily on weekdays times 1 week, 3 times weekly for 2 weeks, 2 times weekly for 2 weeks and weekly for 4 months.

- Results will be discussed at the following QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 6/14/2024

F-689 Free of Accident Hazards/Supervision/Devices

- The facility does provide adequate supervision to ensure residents remain safe.

- Resident #4 is now in a private room and care plan has been reviewed on 6.12.24

- Resident #6 was offered emotional support and denied not knowing the incident had happened on 4.25.24 with no further concerns.

- Resident #3 no longer resides at the facility.

- Education provided to all staff that residents will be immediately separated when showing agitation, making threats or showing aggression, and notify the Administrator immediately to maintain safety for all residents on 6/11/2024.

- Implemented decreased stimuli for all residents on 6/12/2024 by lowering the lights for a period of time during the day.

- Review new or exacerbated behaviors and implement appropriate interventions in morning IDT team meeting weekly on weekdays.

- DON/ADON/ Designee will review hot chart and 24 hour report daily on weekdays. Audits will be completed 3 times weekly for 2 weeks, 2 times weekly for 2 weeks and weekly for 4 weeks to ensure interventions are in place for residents demonstrating new or worsening behaviors.

- Results will be discussed at the following QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 6/14/1024

Respectfully Submitted