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	175332	A. BUILDING _____ B. WING _____	08/09/2021

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ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #152072, 150985, and 148983. This 2567 was electronically sent to the facility on 08/12/21.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This Requirement is not met as evidenced by: The facility reported a census of 61 residents with 17 selected for review. Based on observation,	F 657		

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

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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interview, and record review the facility failed to review and revise the care plan for Residents, (R)49 for refusal of nail care.

Findings included:

- Review of R 49's "Physician Order Sheet" dated 07/30/21, revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion,) major depressive disorder (major mood disorder,) and macular degeneration (progressive deterioration of the retina.)

The "Annual Minimum Data Set (MDS)" dated 12/26/20 assessed the resident had severe cognitive impairment, required extensive assistance for activities of daily living (ADL), and had no impairment in range of motion in upper or lower extremities.

The "Activity of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment [CAA]" did not trigger.

The "Care Plan" reviewed 07/02/21 instructed staff the resident required the assistance of one staff for bathing, personal hygiene, and dressing. The care plan instructed staff to allow enough time for dressing and staff would turn on music in her room to help calm her down when restless. The care plan lacked intervention specifically for nail care and hand hygiene.

Observation on 08/03/21 at 01:31 PM revealed the resident seated in her wheelchair at the dining room table. The resident's fingernails contained a brown substance.

Observation on 08/04/21 at 08:37 AM revealed

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F 657	Continued From page 2 the resident positioned in her bed wearing an incontinence brief and shirt, which she wore on 08/03/21. The resident's night gown was located on her recliner, out of reach. Observation on 08/04/21 at 08:40 AM revealed Certified Nurse Aide (CNA) Q provided morning care to the resident. The resident was incontinent of stool in her brief. The resident's fingers and nails contained a brown substance. The resident resisted hand washing and oral care. CNA Q wiped the resident's hands with a cleansing cloth but did not attempt to clean her fingernails and then took her to breakfast. Interview on 08/05/21 at 08:46 AM with CNA MM revealed she cleaned the resident's fingernails last evening. Interview on 08/09/21 at 10:30 AM with Administrative Nurse D revealed the resident could be resistant to nail care at times and staff could revise the care plan with interventions for nail care and hand hygiene. The facility policy "Nail Care," revised 01/2021, instructed staff to promote cleanliness safety and neat appearance. The facility failed to ensure staff developed interventions and revise the care plan for this dependent resident's resistance to nail care and hand hygiene.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		

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This Requirement is not met as evidenced by:
The facility reported a census of 61 residents with 17 residents sampled, including six residents reviewed for Activities of Daily Living (ADL). Based on interview, record review, and observation, the facility failed to provide facial shaving for two Residents (R)7 and R 37, failed to provide adequate bathing opportunities for one R 16, and failed to provide appropriate nail care, and clean clothing for one R 49.

- The "Physician Order Sheet" (POS), dated 07/29/21, documented Resident (R)7 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 03/12/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. He required extensive assistance of two staff for personal hygiene and a total of two staff for bathing.

The "Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 03/12/21, did not trigger.

The "Quarterly MDS," dated 04/29/21, documented the resident had a BIMS score of two, indicating severe cognitive impairment. He required extensive assistance of one staff for personal hygiene and physical assistance of two staff for bathing.

The "ADLs Care Plan," dated 06/20/21, instructed staff that the resident required set up

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assistance for personal hygiene and assistance of one staff for bathing.

Review of the resident's electronic medical record "EMR", from 07/06/21 through 08/04/21, revealed the resident required assistance of 1-2 staff with personal hygiene needs.

On 08/03/21 at 08:15 AM, staff propelled the resident in his wheelchair to the dining room for breakfast. The resident was unshaven.

On 08/03/21 at 11:50 AM, the resident ate lunch in the dining room. He remained unshaven.

On 08/04/21 at 08:22 AM, the resident was in the hall in his wheelchair. He remained unshaven.

On 08/09/21 at 08:11 AM, the resident rested in the recliner in his room. He remained unshaven.

On 08/04/21 at 02:28 PM, Certified Nurse Aide (CNA) N acknowledged the resident was unshaven and stated residents were to be shaven on their shower days.

On 08/05/21 at 10:10 AM, CNA M stated, the resident did not refuse cares. His shower days were Wednesday and Saturday day shifts. Staff would shave him, sometimes, on his shower days.

On 08/05/21 at 11:13 AM, Licensed Nurse (LN) H stated, staff would shave residents on their shower days. The resident did not refuse cares.

On 08/09/21 at 09:47 AM, Administrative Nurse D stated, staff should offer facial shaving to residents on their bath days.

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The facility policy for "Bath, Shower," revised 01/2021, included: It is the policy of this facility to promote cleanliness, stimulate circulation, and assist in relaxation.

The facility failed to provide facial shaving for this dependent resident on his shower days.

- Review of Resident (R)16's electronic medical record (EMR), under the "Med Diag[nosis]" tab, included a diagnosis of rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The "Quarterly MDS," dated 02/18/21, documented the resident had a BIMS score of 13, indicating she had intact cognition. Bathing activity did not occur during the assessment period.

The "Annual Minimum Data Set" (MDS), dated 05/21/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. Bathing activity did not occur during the assessment period.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 05/21/21, documented the resident required assistance with ADLs.

The "ADLs Care Plan," revised 06/24/21, instructed staff the resident received showers once weekly, but would decline bathing

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F 677	Continued From page 6 assistance at times. Review of the resident's "EMR," dated 07/14/21 through 08/08/21, revealed the resident had three bathing opportunities, which she refused. Staff failed to offer any other bathing opportunities for the resident. On 08/04/21 at 09:04 AM, the resident sat in her room watching TV. Her hair appeared greasy and she had a body odor. On 08/09/21 at 08:30 AM, the resident sat in her room watching TV. Her face had a dried substance around her mouth and her hair appeared greasy and uncombed. On 08/03/21 at 02:48 PM, the resident stated she did not get showered as often as she would like. The resident stated that staff rarely offered the opportunity for her to shower. On 08/04/21 at 02:28 PM, CNA N stated, the resident would at times refuse a shower, but would take one later in the shift or the following day, if offered. On 08/05/21 at 10:10 AM, Certified Nurse Aide (CNA) M stated, staff would offer the resident a shower one time a week. CNA M asked the resident on 08/04/21 if she wanted a shower and the resident refused because she was talking to her daughter on the phone. CNA M stated she did not offer the resident another opportunity for bathing. On 08/05/21 at 11:13 AM, Licensed Nurse (LN) H stated, the resident would refuse showers at times, but staff would be able to convince her to shower at a later time during the shift.	F 677		

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F 677	Continued From page 7 On 08/09/21 at 12:23 PM, Administrative Nurse D stated, residents were to be showered twice a week. If a resident refused a shower, she would expect the staff to offer a shower on the following shift or the following day. The facility policy for "Bath, Shower", revised 01/2021, included: It is the policy of this facility to promote cleanliness, stimulate circulation, and assist in relaxation. The facility failed to provide adequate bathing opportunities for this dependent resident. - Review of Resident (R)49's "Physician Order Sheet," dated 07/30/21, revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion,) major depressive disorder (major mood disorder,) and macular degeneration (progressive deterioration of the retina.) The "Annual Minimum Data Set (MDS)" dated 12/26/2020 assessed the resident had severe cognitive impairment, required extensive assistance for activities of daily living (ADL), and had no impairment in range of motion in upper or lower extremities. The "Activity of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment [CAA]" did not trigger. The "Care Plan" reviewed 07/02/21 instructed staff the resident required the assistance of one staff for bathing, personal hygiene and dressing.	F 677		

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The care plan instructed staff to allow enough time for dressing and staff would turn on music in her room to help calm her down when restless.

Observation on 08/03/21 at 01:31 PM revealed the resident seated in her wheelchair at the dining room table. The resident's fingernails contained a brown substance.

Observation on 08/04/21 at 08:37 AM revealed the resident positioned in her bed wearing an incontinence brief and shirt, which she wore on 08/03/21. The resident's night gown was located on her recliner, out of reach.

Observation on 08/04/21 at 08:40 AM revealed Certified Nurse Aide (CNA) Q provided morning care to the resident. The resident was incontinent of stool in her brief. The resident's fingers and nails contained a brown substance. The resident resisted hand washing and oral care. CNA Q wiped the resident's hands with a cleansing cloth, but did not attempt to clean her fingernails and then took her to breakfast.

Observation on 08/04/21 at 11:22 AM revealed the resident seated in her wheelchair in the dining room, drinking hot chocolate. The hot chocolate spilled onto the resident's shirt and onto to the floor beside her.

Observation on 08/04/21 at 04:30 PM revealed the resident seated in her wheelchair in the dining room, wearing the same shirt with spillage of the hot chocolate on it.

Observation on 08/05/21 at 08:46 AM revealed the resident dressed appropriately and with clean nails.

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Interview on 08/04/21 at 08:50 AM, with CNA Q revealed evening staff should dress the resident in her pajamas. CNA Q stated the resident usually was cooperative with cares, but did not like to take showers so staff provided bed baths.

Interview on 08/04/21 at 04:40 PM with CNA NN revealed the resident did not always cooperate with evening cares, but staff could calm her down and the resident would allow staff to change her into bedtime attire. CNA NN did not notice the spillage of hot chocolate on the resident's clothing.

Interview on 08/05/21 at 08:46 AM with CNA MM revealed she cleaned the resident's fingernails last evening.

Interview on 08/09/21 at 10:30 AM with Administrative Nurse D revealed she would expect staff to provide appropriate clothing to the residents when soiled and when in bed. Administrative Nurse D stated the resident could be resistant to nail care at times.

The facility policy "Nail Care," revised 01/2021, instructed staff to promote cleanliness safety and neat appearance.

The facility failed to ensure this dependent resident received clean, appropriate clothing when soiled and for bed at night, and failed to provide timely nail care for visibly encrusted nails.

- The signed "Physician Order Sheet" (POS), dated 06/30/21, documented the resident had

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diagnoses which included unspecified dementia (progressive mental disorder characterized by failing memory, confusion), and essential tremors (nervous system disorder that causes involuntary and rhythmic shaking).

The Annual "Minimum Data Set" (MDS), dated 01/29/21, documented R37's "Brief Interview for Mental Status" (BIMS) score was seven, which indicated severe cognitive impairment. He required extensive assistance for personal hygiene.

An "Activity of Daily Living (ADL) Care Plan," dated 01/29/19, instructed staff to assist with personal hygiene, but lacked instruction regarding shaving.

R37's "Kardex" (electronic care instructions for direct care staff) instructed staff to assist him with baths on Tuesday & Friday Evenings.

On Wednesday, 08/04/21 at 09:17 AM, R37 sat in his wheelchair in his room. He had several days beard growth on his face.

On 08/05/21 at 05:09 AM, R37 rested in bed. He was unshaven, with several days beard growth on his face.

On 08/05/21 at 12:36 PM, R37 sat in his room in his wheelchair. He just returned from his noon meal and remained unshaven.

On Monday, 08/09/21 at 08:29 AM, R37 sat in his room in his wheelchair. He was unshaven, with several days of growth of beard on his face.

On 08/03/21 at 10:25 AM, a family member stated R37 liked to shave every other day, but

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F 677	Continued From page 11 when she visited, R37 often had facial hair. On 08/04/21 at 03:36 PM, Certified Nursing Assistant (CNA) NN stated staff shaved residents when they are bathed. Residents could also be shaved at other times if they needed it. On 08/09/21 at 12:41 PM Licensed Nurse G stated R37 should be shaved. R37's family member called on Friday (08/06/21) and asked for staff to shave him. She instructed the CNAs to shave him at that time, but it must have been a missed task. Staff did not shave the resident. On 08/09/21 at 01:00 PM, CNA M stated staff shaved residents with their shower if they need it, or anytime they ask to be shaved. R37 has an electric razor, but had trouble using it. Staff shaved him and used a disposable razor if needed. On 08/09/21 at 01:04 PM Administrative Nurse D stated she expected if a family member called and asked for a resident to be shaved, that they would be shaved. Shaving should also be evaluated and provided with the bath. An undated facility policy titled "Grooming Techniques," provided specific steps for shaving, but lacked direction regarding when shaving opportunity should be offered by staff. The facility failed to provide ADL assistance with shaving for this resident.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		

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and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This Requirement is not met as evidenced by:
The facility reported a census of 61 residents with 17 residents sampled, including four residents reviewed for activities. Based on interview, record review, and observation, the facility failed to provide an ongoing program of individualized activities for Resident (R)12.

Findings included:

- Review of Resident (R)12's electronic medical record (EMR), under the "Med Diag[nosis]" tab, included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS), dated 09/16/20, documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating he had moderately impaired cognition. It was very important for the resident to be able to listen to music he liked and he was the primary respondent for the activity preferences.

The "Activity Care Area Assessment" (CAA), dated 09/16/20, did not trigger.

The "Activities Care Plan," dated 07/25/21, instructed staff that the resident enjoyed listening to country/western music, walking outside, and watching the news on the TV.

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Review of the "Activities Log," supplied by the facility, dated June, July, and August, 2021, revealed the resident had no music or music activity offered.

The "Activity Assessment", dated 09/14/20, in the resident's EMR, documented the resident enjoyed watching news on the TV and listening to country music.

On 08/04/21 at 10:09 AM, the resident sat on the side of his bed. The TV was off and no music played in his room.

On 08/04/21 at 11:37 AM, the resident sat on the side of his bed eating lunch. The TV was off and no music played in his room.

On 08/04/21 at 02:26 PM, the resident sat on the side of his bed talking to himself. No music played in his room.

On 08/05/21 at 07:39 AM, the resident sat on the side of his bed talking to himself. The TV was off and no music played in his room.

On 08/09/21 at 08:30 AM, the resident stated he liked to listen to country music, but did not have a radio.

On 08/04/21 at 02:28 PM, Certified Nurse Aide (CNA) N stated, the resident liked to stay in his room and watch the news on the TV. CNA N stated the resident did not have a radio.

On 08/05/21 at 10:10 AM CNA M stated, the resident did not have music in his room.

On 08/09/21 at 08:49 AM, Activity staff Z stated,

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F 679	Continued From page 14 the resident preferred to stay in his room and did not have a radio. The resident enjoyed watching the news on the TV. On 08/05/21 at 11:13 AM, Licensed Nurse (LN) H stated, the resident always sat on the side of his bed. He enjoys watching the news on TV, but he did not have a radio to listen to music. LN H stated she had never asked the resident if he liked to listen to music. On 08/09/21 at 09:47 AM, Administrative Nurse D stated, staff should respect each resident's activity preferences. She would expect the staff follow the care plan for activities which each resident enjoyed. The facility policy for "Activity Policy and Procedure Manual," revised 01/2021, included: The Activity Director shall interview the resident and develop an individual activity plan based on the resident's needs and interests. This initial assessment shall be the basis for the activity plan in the resident's care plan. The facility failed to provide an ongoing program of individualized activities for this dependent resident who enjoyed listening to music.	F 679		
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.	F 684		

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This Requirement is not met as evidenced by:
The facility reported a census of 61 residents. The sample contained 17 residents with one resident reviewed for non-pressure related skin issues. Based on observation, interview, and record, review the facility failed to implement care planned skin protection interventions of pressure reducing boots on both feet and repositioning every two to three hours for one resident, Resident (R) 29.

Findings included:

- The signed "Physician Order Sheet" (POS), dated 07/29/21, documented R29's diagnoses included: peripheral vascular disease (abnormal condition affecting the blood vessels), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion).

An "Annual Minimum Data Set" (MDS) dated 06/04/21 documented R29 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. He required extensive assistance with bed mobility and transfer. The resident had one venous /arterial ulcer present and required applications of ointments/medications other than to feet.

An "Activity of Daily Living [ADL] Functional/ Rehabilitation Potential Care Area Assessment" documented R29 required staff assistance with ADLs due to multiple co-morbidities. He required around the clock nursing care and supervision to ensure his daily needs were met. He made minimal improvements recently after long treatment for osteomyelitis (local or generalized

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infection of the bone and bone marrow). R29 used a wheelchair for locomotion, had a suprapubic catheter (urinary bladder catheter inserted through the skin) to drain his urine, and had fecal incontinence.

R29's "Skin Care Plan" listed interventions as follows:

Staff would encourage good nutrition and hydration in order to promote healthier skin, dated 06/29/20.

Staff would use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, dated 06/29/20.

The resident would have pressure reducing boots to feet at all times, dated 07/01/20.

The resident would have a pressure reducing cushion to the wheelchair as a preventative measure, dated 07/12/20.

Staff would float the resident's heels, dated 07/21/20.

The registered dietician would be available to suggestion changes as necessary, dated 07/21/20.

Staff would turn and reposition the resident approximately every 2-3 hours, dated 07/21/20.

The resident would be followed by the wound doctor, dated 07/21/20.

Staff would see physician orders for current treatments, dated 04/27/21.

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The resident had a low air loss mattress to the bed and staff would check for proper functioning every shift, dated 07/08/21.

On 08/04/21 at 08:45 AM, R29 wore a long boot on the left foot and lower leg. The right leg revealed no boot and the right heel sat against the air mattress with the ball of the right foot and toes pressed against the footboard.

On 08/04/21 at 11:15 AM, R29 sat in his recliner with the footrest out, feet suspended, boot on left foot, no boot on the right foot and covered with blue blanket.

On 08/04/21 at 04:15 PM , approximately five hours later, the resident remained in his recliner. Certified Nursing Assistant (CNA) MM and CNA NN entered his room and used a full mechanical lift to transfer him from the recliner to a supine (back) position in his bed. R29 wore a boot to the left foot and had no boot present on the right foot.

On 08/04/21 at 04:25 PM, Licensed Nurse (LN) K exposed the left back of R29's calf and an existing scab measured 0.8 centimeters (cm) by 0.3 cm. An existing wound on the left heel measured 11.5 cm by 8.0 cm. An existing wound on the right heel measured 8.0 cm by 4.5 cm.

On 08/04/21 at 04:53 PM, LN K stated R29 should be turned every two hours and repositioned when in the recliner. He should also have boots on both feet. LN K verified she did not offer R29 repositioning in the recliner.

On 08/05/21 at 07:49 AM CNA OO stated R29 wore special boots, which included a grey boot on the left foot, a blue boot on the right foot, and he

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F 684	Continued From page 18 needed repositioning every two to three hours. On 08/09/21 at 01:31 PM, Administrative Nurse D stated it was expected that staff would implement the interventions care planned for R29, including turning and repositioning every two to three hours whether in the bed, recliner or wheelchair, and keeping his boots on both feet. A facility policy addressing following the plan of care was not available. The facility failed to implement care planned skin protection interventions of pressure reducing boots on both feet and repositioning every two to three hours.	F 684		
F 686 SS=D	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: The facility reported a census of 61 residents with 17 selected for review, which included two residents selected for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure sanitary dressing changes for one Resident (R)8 of the two residents	F 686		

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reviewed.

Findings included:

- Review of R8's "Physician Order Sheet," dated 07/27/21, revealed diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness,) and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).

The "Quarterly Minimum Data Set (MDS)," dated 04/29/21, assessed the resident had moderate cognitive impairment and required extensive assistance for transfer and bed mobility. The resident was at risk for pressure ulcers, had preventive measures in place, and this MDS indicated no current pressure ulcer.

The "Pressure Ulcer Care Area Assessment (CAA)," assessed the resident was at risk for pressure ulcers and had preventive measures in place.

The "Care Plan," reviewed 07/21/21 instructed staff to encourage the resident to lay down twice a day, provide heel protectors to his feet when in bed, pressure reducing mattress to his bed, and pressure reducing cushions to wheelchair and recliner. The resident required staff assistance for personal hygiene, transfers, repositioning, and dressing. The care plan indicated the resident had a pressure ulcer to his left and right buttock.

Review of the "Pressure Ulcer Weekly Note" in the electronic medical record, revealed the resident developed a pressure ulcer on his right and left buttocks at intervals from 12/29/20 to

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present that healed and then reoccurred. The resident repositioned himself in his bed and chair, and the facility had pressure ulcer preventive measures in place.

A "Physician's Order," dated 07/31/21, instructed staff to cleanse the resident's right and left buttocks with would cleanser and apply A and D ointment (an ointment with vitamin A and vitamin D) mixed with collagen powder (a substance that promotes wound healing) and cover with gauze.

Observation, on 08/03/21 at 10:30 AM, revealed the resident seated in his wheelchair in his room. The resident was alert to person and place and stated he did have a sore on his bottom. The resident stated he took himself to the bathroom, could transfer himself into and out of his recliner.

Observation on 08/04/21 at 10:11 AM revealed Licensed Nurse (LN) J prepared to provide wound care to the resident. LN J placed a paper package of gauze pads and wound cleanser directly on the resident's bedside table without a barrier or cleaning the table.
LN J donned gloves cleansed the areas and with the same pair of gloves applied the A&D ointment directly to the wound with gloved hands. LN J removed her gloves and donned a clean pair of gloves without performing hand hygiene and applied the bordered foam dressing.
Observation at the time of wound care revealed the area on the resident's right buttocks was healed and the resident's left buttocks contained two open areas of pink tissue.

Observation on 08/09/21 at 10:00 am revealed LN I prepared to provide wound care to the resident. LN I placed gauze sponges and wound cleanser directly on the resident's bedside table

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without cleaning the table or applying a barrier. The wounds on the resident's left buttocks were pink in color, nearly closed. LN I donned a pair of gloves, moved a trash can, and then assisted the resident to stand and lower his pants. With the same gloved hands, LN I cleansed the wound with the wound cleanser and gauze. Without changing gloves, LN I applied the A&D ointment with a cotton swab to the areas on the resident's buttocks then applied the bordered foam dressing. LN I then placed the container of wound cleanser back in the treatment cart drawer without sanitizing it.

Interview on 08/04/21 at 10:20 AM with LN J revealed a barrier should be utilized for dressing supplies after sanitizing the table top. LN J confirmed hand hygiene should be performed after removal of gloves and prior to donning gloves, and a cotton tipped swab should be used to apply the ointment directly to the wound.

Interview on 08/09/21 at 10:30 AM with LN I confirmed the resident's table should be sanitized and a barrier placed to contain the wound care products. LN I stated she would sanitize the wound cleanser with a sanitary wipe. LN I confirmed she should perform hand hygiene and glove changes after cleansing the wound and applying the ointment and dressing.

Interview on 08/09/21 at 11:00 AM with Administrative Nurse D confirmed staff should perform hand hygiene after glove changes, and staff should sanitize the bedside table and place a barrier for the wound care products.

The facility policy "Wound Care," revised 09/2020, instructed staff to place supplies on a clean surface and hand washing must be done as

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F 686	Continued From page 22 indicated in the procedure. The facility failed to provide this resident with wound care in a sanitary manner to prevent the spread of infection.	F 686		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This Requirement is not met as evidenced by: The facility reported a census of 61 residents. Based on interview and record review the facility failed to use the services of a registered nurse for eight consecutive hours a day, on four days in a three-month period between 05/01/21 to 07/31/21. Findings Included: - Review of the facility schedules, from 05/01/21 to 08/09/21, daily staff postings, and hours worked summaries revealed the following: 1. A facility staffing schedule titled "When to Work.Com" dated 05/08/21, which scheduled a registered nurse on the 02:00PM to 10:00 PM shift.	F 727		

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A facility staff posting sheet titled "Nurse Staff information" dated 05/08/21 documented one registered nurse for the 02:00PM to 10:00 PM shift.

A "Labor Hours Summary Report" dated 05/08/21 documented 4.88 registered nurse hours.

2. A facility staffing schedule titled "When to Work.Com" dated 05/15/21 revealed no scheduled registered nurse.

A facility staff posting sheet titled "Nurse Staff information" dated 05/15/21 documented no registered nurse on duty.

A "Labor Hours Summary Report" dated 05/15/21, documented no registered nurse hours.

3. A facility staffing schedule titled "When to Work.Com" dated 05/22/21 revealed no scheduled registered nurse.

A facility staff posting sheet titled "Nurse Staff information" dated 05/22/21 documented no registered nurse on duty.

A "Labor Hours Summary Report" dated 05/22/21 documented no registered nurse hours.

4. A facility staffing schedule, titled "When to Work.Com" dated 07/17/21 identified a registered nurse scheduled for the 10:00 PM to 06:00 AM shift.

A facility staff posting sheet titled "Nurse Staff information" dated 07/17/21 documented one registered nurse for the 10:00 PM to 06:00 AM shift.

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F 727	Continued From page 24 A "Labor Hours Summary Report" dated 07/17/21 documented 5.67 registered nurse hours. On 08/09/21 at 09:51 AM Administrative Staff A verified on 05/08/21 the facility had a registered nurse on duty for 6.3 consecutive hours. The facility had no registered nurse on duty on 05/15/21 nor on 05/22/21 and on 07/17/21 a registered nurse was on duty for 5.67 consecutive hours. Administrative Staff A stated there must have been a registered nurse scheduled, but called off. Administrative Staff A further verified it is a requirement to have eight hours of registered nurse coverage a day. On 08/09/21 at 02:50 PM Administrative Nurse D stated it is expected the facility has a registered nurse on duty for at least eight consecutive hours every day. The facility was unable to provide a policy regarding registered nurse daily staffing. The facility failed to use the services of a registered nurse for eight consecutive hours on four days in a three-month period, on 05/08/21, 05/15/21, 05/22/21, and 07/17/21.	F 727		