STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175403	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	**408 E MAIN PO BOX 37 GOESSEL, KS 67053**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation # KS00133937. The 2567 was electronically sent to the facility on 10/09/18.	F 000		
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 42 residents with 6 selected for sample review. Based on observation, interview, and record review the facility failed to provide timely assessment and treatment for one resident (#1) of 3 reviewed for pressure ulcers. The hospice provider assessed the resident with skin breakdown on 8/2/18, delivered an air mattress for the resident's bed on 8/3/18, and licensed facility staff failed to identify, measure and evaluate the area for treatment until 8/14/18 (12 days after the breakdown occurred). Findings included:	F 686		

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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- Resident #1's diagnosis from the closed electronic clinical record included dementia (progressive mental disorder characterized by failing memory, and confusion) with behavioral disturbance.

A significant change MDS (minimum data set), dated 6/13/18, identified the resident as moderately impaired of cognition with long and short-term memory loss, required extensive assistance of staff for ADLs and without pressure ulcers.

The CAA (care area assessment) for cognition, dated 6/19/18, included the resident had a diagnosis of dementia, and an expected continued decline in cognition, with behavioral disturbances, experienced forgetfulness, confusion and disorientation.

The CAA for pressure ulcers, dated 6/20/18, identified the resident at risk for pressure ulcer development due to mobility limitations and nutritional status. The resident had an indwelling urinary catheter which could help with reducing the risk of skin breakdown, but he/she experienced bowel incontinence and needed to be kept as clean and dry as possible. The staff needed to continue to provide assistance with bed mobility and repositioning routinely.

The Braden Pressure Ulcer Risk assessment, identified the resident at high risk, as follows:
2/5/18 - scored 18.
3/30/18 - scored 17.
6/7/18 - scored 17.
Interpretation of Scores: 19 or Higher - NOT AT RISK - No interventions necessary; 15-18 - AT

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RISK - If other major risk factors are present (e.g., advanced age, fever, poor dietary intake of protein, Diastolic BP < 60, hemodynamic instability) advance to next level of risk; 13-14 - MODERATE RISK - If other major risk factors are present advance to next level of risk. 10-12 - HIGH RISK; 9 or Less - VERY HIGH RISK.

The resident's care plan, dated 6/22/18, included
Assist into wheelchair when restless in bed.
Double cushions to wheelchair for prevention of skin breakdown.
Change position every 2 hours.
Hospice provided low air loss air mattress. Added 8/3/18.
Skin excoriation to buttocks. Added 8/13/18.
Continue to encourage position changes and when combative leave and re-approach. Added 8/13/18.

The care plan failed to instruct the staff in changing the pressure relieving cushion from the wheelchair to the recliner.

Review of nursing notes, dated 8/3/18 at 9:27 AM, a late entry recorded on 8/17/18, identified the facility received a low air loss mattress from hospice for the resident.

A nursing note on 8/6/18 at 3:28 AM, a late entry on 8/6/18 at 3:34 AM, documented the resident awakened and presented with restlessness and grimacing. A PRN (as needed) pain medication was administered for buttock pain.

Nursing notes on 8/14/18 at 11:42 AM, identified a skin assessment completed and assessed excoriation to the buttocks (no specific area identified), red in color and dry. Noted a chair

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cushion and barrier cream in use.

Review of hospice notes included:
8/2/18 Hospice Nurse log documented the resident was restless at night, was not sleeping, and noted breakdown to his/her buttock area. Intervention included a low air loss mattress ordered and to continue with the current plan of care.

An additional hospice report, dated 8/2/18 at 4:01 PM, a "nursing visit record" included that the facility reported the resident was not sleeping and sat up in his/her wheelchair all night. Breakdown to the buttocks crease formed despite gel cushion. RN (registered nurse) encouraged to place gel cushion in the recliner during use and transfer back and forth from the wheelchair to the recliner. A reddened area, non-blanchable, to the buttock crease, measured approximately 0.3 cm long. Resident currently receiving barrier cream and offloading, at that time.

On 10/3/18 at 11:59 AM, direct care staff G reported the resident needed extensive assistance for all cares, except sometimes could feed him/her self. The resident had a catheter but was occasionally incontinent of bowel and reported the resident often refused care, especially in the evenings. The staff did not recall the resident having any pressure ulcers or special treatments.

On 10/3/18 at 4:45 PM, administrative nursing staff C reported believing the resident's overall decline in dementia/behaviors, intake and the dying process contributed to the wound the resident developed.

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On 10/4/18 at 5:00 AM, licensed nursing staff D reported that the resident was frequently awake during the night. Often, he/she would follow staff in his/her wheelchair, sometimes could be distracted with another activity, and slept in the recliner in the lobby area a lot, due to getting out of bed frequently and being a high fall risk. The staff did not recall the resident had a pressure ulcer.

On 10/8/18 at 10:30 AM, administrative nursing staff B reported being unaware why the licensed staff did not assess the resident's bottom after the hospice reported breakdown. Staff B later reported the normal wound care nurse was on vacation and another nurse completed the treatments and measurements that week and should have assessed the wound, which hospice services had identified, on 8/2/18.

On 10/8/18 at 10:36 AM, licensed nursing staff E recalled the noted "breakdown" to the resident's bottom was related to shearing, and was not a pressure ulcer on 8/2/18 when observed. A low air loss mattress, application of calmoseptine and a gel cushion for use in the recliner were provided to ensure the resident remained free of further breakdown. The staff later reviewed other documentation and verified the development of a non-blanchable 0.3 cm breakdown in the crease of the resident's buttock area.

The facility policy, dated 5/18, included: all residents developing or admitted with pressure ulcers shall receive appropriate monitoring and treatment to promote healing.

The facility failed to assess, monitor and provide care and treatment in a timely manner to promote

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F 686	Continued From page 5 healing of a pressure ulcer which developed. The facility failed to assess and treat the resident, assessed by a hospice nurse on 8/2/18, and found to have developed a pressure ulcer to the buttock crease, until 8/14/18, 12 days later.	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: The facility reported a census of 42 residents with 6 selected for sample review. Based on observation, interview, and record review the facility failed to ensure 1 resident (#1) of 3 reviewed for accidents, remained free of falls, when the staff failed to ensure the personal safety alarm, care planned for the resident, was turned on after the provision of cares. The resident subsequently arose from the bed, fell to the floor, hitting his/her head and received skin tears to his/her arm. Findings included: - Resident #1's diagnosis from the closed electronic clinical record included dementia with behavioral disturbance and unsteadiness on his/her feet. The annual MDS (minimum data set), dated	F 689		

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11/17/17, identified the resident unable to complete the BIMS (brief interview of mental status) and staff identified the resident with long and short-term memory impairment, required assistance of staff for ADLs (activities of daily living), and indicated the resident without falls since admission.

A significant change MDS, dated 3/28/18, identified the resident as severely impaired of cognition with long and short-term memory loss, needed assistance with ADLs, including mobility and had 1 fall since the prior assessment.

A significant change MDS, dated 6/13/18, identified the resident as moderately impaired of cognition with long and short-term memory impairment, and with 2 falls since the prior assessment.

The CAA (care area assessment) for cognition, dated 6/19/18, included the resident had a diagnosis of dementia (expected continued decline slowly over time) with behavioral disturbances, experienced forgetfulness, confusion and disorientation, per the history and physical and physician's orders. At times, the resident shows agitation/frustration with family and staff when unable to understand. Additionally, the resident experienced reduced ADL ability, however, believes that he/she can stand, walk and care for him/herself due to dementia and confusion. The resident required monitoring for safety awareness and the risk of falling.

The CAA for falls, dated 6/20/18, identified the resident at increased risk for falls due to cognitive deficits, poor safety awareness, poor

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decision-making abilities, potential for pain, potential side effects of medications, and mobility limitations. The resident experienced actual falls on 4/13/18 & 5/1/18.

Review of the residents Fall Risk Assessments, included:
2/5/18 - scored 18.
3/30/18 - scored 15.
6/7/18 -- scored 25.
The legend identified the Fall Risk Scores of 10 or higher represented a high risk for falls.

The resident's care plan, dated 6/22/18, included the following fall interventions:
1. Sit with resident at the bar or at a table in the dining room when anxious.
2. Close supervision during meals.
3. Staff supervise when awake on 3rd shift.
4. Assist into wheelchair, when restless, in bed.
5. When assigned 1:1 stay with the resident.
6. Thirty-minute checks at nighttime, when in room, or provide activity in the common area.
7. Pressure sensitive alarm to bed/chair when in bed/chair.
8. Keep call light within reach.
9. One to two staff extensive assistance with transfers.
10. Ensure alarm is plugged in before leaving the room.
11. If not sleeping, call spouse; don't take resident to another unit for monitoring.
12. Provide structured activity when awake and getting restless prior to supper time. 5/1/18
13. Call hospice when having behaviors and when up at night with behaviors. 7/3/18
14. Educate staff to double check alarm is connected before leaving the room. 7/24/18
15. Two staff assist for transfers. 7/26/18

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Nursing notes dated 6/22/18 at 12:03 AM, identified the staff assisted the resident to bed at approximately 2100 (9PM) and was up again by 2230 (10:30 PM). The resident's alarm sounded when he/she attempted to get out of bed. Staff took the resident to a commons area and assisted him/her into the recliner with the chair alarm in place and working properly.
Nursing notes on 7/25/18 at 12:38 AM, identified staff notified the physician at approximately 10:57 PM, on 7/24/18, of a fall with the resident hitting his/her head. The staff assessed a small bump with a pinpoint red center, without bleeding present with skin tears to the left upper arm, measuring 2.50 cm (centimeter) by 1 cm and 5.50 cm by 1 cm. The resident appeared to have gotten him/her self out of bed and ambulated to the hallway where he/she fell. The resident's wheelchair and walker were both noted in his/her room and the resident was barefoot. The resident's bed pressure sensitive alarm failed to sound. Staff implemented an intervention educating staff to double check that alarms are connected before leaving the resident's room.

A review of the facility fall investigation identified the staff members last caring for the resident failed to turn the pressure sensitive alarm on after providing the cares.

On 10/8/18 at 10:56 AM, administrative nursing staff B reported that the fall committee reviewed the resident's fall and identified that the staff failed to turn on the alarm, with the resident subsequently falling. At the time of the review, all staff received re-education regarding ensuring the residents with alarms are in proper operation before staff exit the resident's room. The staff

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F 689	Continued From page 9 verified the staff on duty at the time of the fall were included in the re-education. The facility policy, dated 9/3/18, included the management committee would help determine a pattern/cause for the fall and review and implement individualized interventions to help reduce the risk of and/or eliminate future falls. The facility failed to provide assistive devices and or supervision to prevent the resident from falling, as planned, when staff failed to turn on a pressure sensitive alarm, used for detection of the resident getting up unassisted, with the resident falling and receiving a bump on the head and a skin tear on his/her arm.	F 689		