STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045201	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHAPEL WOODS HEALTH AND REHABILITATION	**1440 EAST CHURCH WARREN, AR 71671**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, record review and interview the facility failed to ensure meals for residents at the same dining table were served together to promote dignity and respect for of 9 out of 13 non-sample mix residents who received meal trays at the same tables. These failed practices had the potential to affect residents who eat in the dining room as documented on a list provided by the Administrator on 3/6/2020 at 8:24 am. The findings are: On [DATE] at 7:00 AM Staff were not serving by tables. Three residents were at a center table, 1 Resident was served while the 2 others waited to be served while others were served at other tables. One resident at another table was served while 2 other residents at the same table waited for their trays. At 07:22 AM the 2 residents at the center table were served. On 3/5/2020 at 2:30 pm, the Dietary Manager was asked, Are you aware that some Residents must wait 15 minutes or more between trays being served at the same table? She stated, Some residents are not always in there, or are sitting in a different area. She was asked, What could have been done differently? She stated, The resident that needed feeding should have been moved to the long table where the feeders are. On 3/5/2020 at 2:40 pm, the Administrator was asked, Are you aware that some residents must wait 15 minutes or more between trays being served at the same table? She stated, Some residents move to a different table or decide to eat in their room. She was asked, What could have been done differently? She stated, We should always serve each table completely.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure resident care was provided in a private area to promote dignity and respect for 1 (Resident #84) of 3 (Residents #288, #40, and #84) sampled residents who had treatment orders. The findings are: Resident #84 had [DIAGNOSES REDACTED]. A Modified Quarterly assessment dated [DATE] documented Resident #84 was severely impaired in cognitive status. a. A physicians order with a revised date of 3/03/20 documented, Cleanse scratch to forehead w/wd (with / wound) cleanser. pat dry w (with)/4x (by)4 gauze. Apply Cacitracin and cover w/dry drng (dressing) . b. On 3/03/20 at 9:02 AM, Resident #84 was sitting in day area with his walker positioned in front of him. A bruise was on the right side of his head toward the top. Licensed Practical Nurse (LPN) #2 wiped dried blood from the resident's head while he was sitting in the day area with a 4x4. She went in the medication room, came out with supplies, and asked the resident to come to his room. c. On 3/6/2020 at 10:15 AM, LPN #3 was asked, Should treatment be performed in a private area? She stated, Yes. d. On 3/6/2020 at 10:30 AM, the Director of Nursing (DON) was asked, Should treatment be performed in a private area? She stated, Yes.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the facility abuse prohibition policies and procedures were followed by not reporting an injury of unknown origin immediately to the Administrator and the Office of Long Term Care and an investigation and appropriate protective measures were immediately initiated to prevent further potential abuse for 1 (Resident #84) of 1 sampled resident. These failed practices had the potential to affect 56 residents who are cognitively impaired according to a list provided by the Administrator on 03/12/20 at 3:34 PM. The findings are: Resident #84 had [DIAGNOSES REDACTED]. A Modified Quarterly Minimum Data Set with an Assessment Reference date of 1/27/20 documented the resident scored 3 (0 - 7 indicates severely impaired) per a Brief Interview for Mental Status, required supervision with set-up help only for bed mobility and transfers, independent with setup help only for walking in room, walking in corridor, locomotion on/off unit, independent with setup help only with toilet use. a. A Care Plan dated as initiated on 02/03/2020 documented, AMBULATION: The resident requires limited to extensive assistance by x (times) 1 staff to walk as necessary with walker . LOCOMOTION: The resident requires extensive assistance by (X1) staff for locomotion using w/c, walker . b. An Incident Note dated 1/13/20 at 5:15 PM, documented, .Nature/Description of Incident: Nurse was called to the resident's room by family member. Resident was found in bed with bruise to middle of forehead and left elbow. Resident was assessed. No other injury found, and resident did not complain of pain. CNA (Certified Nursing Assistant) was questioned and the bruise was not present earlier in the evening. Resident Description: Resident Unable to give Description. Immediate Action Taken: Description: Resident was assessed and found without further injury or complaint. Neuro-checks were started, and padding was applied to resident walker . Attached to the incident report was a form titled, DON (Director of Nursing) /Designee Risk Management Investigation, dated 1/14/20. It documented, Client slipped and fell into his walker, striking an area between his eyes. Large area noted to his left upper arm from striking his arm. Applied ice pack to the area to prevent any further bleeding. Head to toe assessment completed . c. On 3/05/20 at 3:15 PM, the DON was asked if a reportable was submitted for Resident #84 for an incident report dated 1/13/2020. She stated, No because we know what happened. We suspected he hit his head on his walker. We observed him hitting his head against the walker before, but it never caused a bruise. We talked with his family, and we both came to a conclusion that what had happened. She was asked if she completed an investigation. She stated, That's a nurse thing, I'll have to check with them. d. On 3/05/20 at 3:35 PM The Nurse Consultant was asked if a reportable was submitted for Resident #84 for an incident report dated 1/13/2020. She stated, We didn't do a reportable or an I&A (Incident and Accident) because we know what happened. She was asked who witnessed the incident. She stated, No one witnessed it. e. On 3/05/20 at 3:55 PM, the ADON (Assistant Director of Nursing) was asked if he received any witness statements from the staff. He stated, No because we decided what had happen to him, and we didn't need to get any statements. f. On 3/05/20 at 4:02 PM, Family Member #1 was asked if she was at the facility when a bruise was found on Resident #84 head. She stated, I go by every afternoon. That afternoon I went to get his clothes and he was in the meal area eating. I noticed a bruise on his forehead, and I asked him what happened. He motioned his head that he didn't know. I told him yea you have a bruise. I told an Aide and asked her if he fell , and she didn't even know he had it. I took him to his room to put on his pajamas and I saw another bruise on his arm, and that's when I got the nurse, and the nurse didn't know anything about it either. He had been in the living area, and no one had noticed it. g. The facility's policy and procedure titled, Abuse Prevention, provided by the Administrator on 3/06/2020 at 10:15AM, documented, . All reports of resident abuse, neglect, injuries of unknown source . are promptly and thoroughly investigated by facility management . 2. The individual conducting the investigation will, as a minimum: Interview the person (s) reporting the incident . interview staff members (on all shifts) who have had contact with the resident during the 24 hour period prior to the time of the incident .review all events preceding the alleged incident . witness reports will be in writing. Witnesses will be required to sign and date such reports . The facility will ensure all allegations of abuse . including injuries of unknown origin . are reported immediately . administrator will make an initial report to the local

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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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) police department as applicable and to the state licensing agency not more than 2 hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury. The administrator or designee will report to the state licensing agency within 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury . A final report with findings of the investigation will be made to the state agency within five (5) business days .
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an injury of unknown origin was reported to the Administrator within 2 hours, which resulted in delays in initiating an investigation to rule out possible abuse/neglect and in reporting the injury to the Office of Long Term Care (OLTC) and other agencies in accordance with state law for 1(Resident #84) of 1 sampled resident. This failed practice had the potential to affect Resident # 84. The findings are: Resident #84 had [DIAGNOSES REDACTED]. A Modified Quarterly Minimum Data Set with an Assessment Reference date of 1/27/20 documented the resident scored 3 (0 - 7 indicates severely impaired) per a Brief Interview for Mental Status, required supervision with set-up help only for bed mobility and transfers, independent with setup help only for walking in room, walking in corridor, locomotion on/off unit, independent with setup help only with toilet use. a. A Care Plan dated as initiated on 02/03/2020 documented, AMBULATION: The resident requires limited to extensive assistance by x (times) 1 staff to walk as necessary with walker . LOCOMOTION: The resident requires extensive assistance by (X1) staff for locomotion using w/c, walker . b. An Incident Note dated 1/13/20 at 5:15 PM, documented, .Nature/Description of Incident: Nurse was called to the resident's room by family member. Resident was found in bed with bruise to middle of forehead and left elbow. Resident was assessed. No other injury found, and resident did not complain of pain. CNA (Certified Nursing Assistant) was questioned and the bruise was not present earlier in the evening. Resident Description: Resident Unable to give Description. Immediate Action Taken: Description: Resident was assessed and found without further injury or complaint. Neuro-checks were started, and padding was applied to resident walker . Attached to the incident report was a form titled, DON (Director of Nursing) /Designee Risk Management Investigation, dated 1/14/20. It documented, Client slipped and fell into his walker, striking an area between his eyes. Large area noted to his left upper arm from striking his arm. Applied ice pack to the area to prevent any further bleeding. Head to toe assessment completed . c. On 3/05/20 at 3:15 PM, the DON was asked if a reportable was submitted for Resident #84 for an incident report dated 1/13/2020. She stated, No because we know what happened. We suspected he hit his head on his walker. We observed him hitting his head against the walker before, but it never caused a bruise. She was asked if she completed an investigation. She stated, That's a nurse thing, I'll have to check with them. d. On 3/05/20 at 3:35 PM, The Nurse Consultant was asked if a reportable was submitted for Resident #84 for an incident report dated 1/13/2020. She stated, We didn't do a reportable or an I&A (Incident and Accident) because we know what happened. She was asked, Who witnessed the incident? She stated, No one witnessed it. e. On 3/05/20 at 3:55 PM, the ADON (Assistant Director of Nursing) was asked if he received any witness statements from the staff. He stated, No because we decided what had happen to him, and we didn't need to get any statements. f. On 3/05/20 at 4:02 PM, Family Member #1 was asked if she was at the facility when a bruise was found on Resident #84's head. She stated, I go by every afternoon. That afternoon I went to get his clothes and he was in the meal area eating. I noticed a bruise on his forehead, and I asked him what happened. He motioned his head that he didn't know. I told him yea you have a bruise. I told an Aide and asked her if he fell , and she didn't even know he had it. I took him to his room to put on his pajamas and I saw another bruise on his arm, and that's when I got the nurse, and the nurse didn't know anything about it either. He had been in the living area, and no one had noticed it.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an injury of unknown origin was promptly and thoroughly investigated to rule out potential abuse or neglect and facilitate the ability to implement protective measures to prevent further potential injury for 1 (Resident #84) of 1 sampled resident who had an injury of unknown origin. This failed practice had the potential to affect Resident #84. The findings are: Resident #84 had [DIAGNOSES REDACTED]. A Modified Quarterly Minimum Data Set with an Assessment Reference date of 1/27/20 documented the resident scored 3 (0 - 7 indicates severely impaired) per a Brief Interview for Mental Status, required supervision with set-up help only for bed mobility and transfers, independent with setup help only for walking in room, walking in corridor, locomotion on/off unit, independent with setup help only with toilet use. a. A Care Plan dated as initiated on 02/03/2020 documented, AMBULATION: The resident requires limited to extensive assistance by x (times) 1 staff to walk as necessary with walker . LOCOMOTION: The resident requires extensive assistance by (X1) staff for locomotion using w/c, walker . b. An Incident Note dated 1/13/20 at 5:15 PM, documented, . Nature/Description of Incident: Nurse was called to the resident's room by family member. Resident was found in bed with bruise to middle of forehead and left elbow. Resident was assessed. No other injury found, and resident did not complain of pain. CNA (Certified Nursing Assistant) was questioned and the bruise was not present earlier in the evening. Resident Description: Resident Unable to give Description. Immediate Action Taken: Description: Resident was assessed and found without further injury or complaint. Neuro-checks were started, and padding was applied to resident walker . Attached to the incident report was a form titled, DON (Director of Nursing) /Designee Risk Management Investigation, dated 1/14/20. It documented, Client slipped and fell into his walker, striking an area between his eyes. Large area noted to his left upper arm from striking his arm. Applied ice pack to the area to prevent any further bleeding. Head to toe assessment completed . c. On 3/05/20 at 3:15 PM, the DON was asked if she completed an investigation. She stated, That's a nurse thing, I'll have to check with them. d. On 3/05/20 at 3:35 PM The Nurse Consultant was asked if a reportable was submitted for Resident #84 for an incident report dated 1/13/2020. She stated, We didn't do a reportable or an I&A (Incident and Accident) because we know what happened. She was asked who witnessed the incident. She stated, No one witnessed it. e. On 3/05/20 at 3:55 PM, the ADON (Assistant Director of Nursing) was asked if he received any witness statements from the staff. He stated, No because we decided what had happen to him, and we didn't need to get any statements. f. On 3/05/20 at 4:02 PM, Family Member #1 was asked if she was at the facility when a bruise was found on Resident #84's head. She stated, I go by every afternoon. That afternoon I went to get his clothes and he was in the meal area eating. I noticed a bruise on his forehead, and I asked him what happened. He motioned his head that he didn't know. I told him yea you have a bruise. I told an Aide and asked her if he fell , and she didn't even know he had it. I took him to his room to put on his pajamas and I saw another bruise on his arm, and that's when I got the nurse, and the nurse didn't know anything about it either. He had been in the living area, and no one had noticed it. g. The facility's policy and procedure titled, Abuse Prevention, provided by the Administrator on 3/06/2020 at 10:15AM, documented, . All reports of resident abuse, neglect, injuries of unknown source . are promptly and thoroughly investigated by facility management .
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure comprehensive care plans were updated to address specific, identified care needs to prevent potential inadequate care for 1 (Resident #64) of 7 (Residents #17, 24, 27, 58, 60, 64, and 71) sampled residents who were at risk for pressure ulcers. The findings are: Resident #64 had [DIAGNOSES REDACTED]. The Minimum Data Set documented his mental status was cognitively impaired. b. The Care Plan, not dated, documented the resident had pressure ulcers to sacrum, right buttocks, and right heel. The care plan did not document that Resident #64 had a pressure ulcer to his lower right leg. c. A physician order [REDACTED]. Cleanse right lateral lower leg w/wd (with/wound) cleanser. Pat dry w/4x4 gauze. Apply Santyl and cover w/[MEDICATION NAME] 4x4 bordered gauze. d. On 3/05/20 at 1:28 PM Licensed Practical Nurse (LPN) #3 provided wound care to a wound on the right side of Resident #64's leg. e. On 3/6/2020 at 10:15 AM, LPN #3 was asked, Should the pressure ulcer to Resident #64's right leg be care planned? He stated, Yes. f. On 3/6/2020 at 10:30 AM, the Director of Nursing (DON) was asked, Should the pressure ulcer to Resident #64's right leg be care planned? She stated, Yes. g. On 3/6/2020 at 10:51 AM, During a phone interview

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) with LPN #4, she was asked, Should the pressure ulcer to Resident #64's right leg be care planned? She stated, Yes.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure oral care was provided to promote good hygiene for 1 (Resident #60) of 21 (Resident #'s 4, 8, 10, 17, 19, 27, 28, 35, 38, 48, 53, 59, 60, 62, 63, 64, 67, 70, 71, 76, and 79) sampled residents who required assistance with oral care. This failed practice had the potential to affect 23 residents who needed assistance with oral care according to the list provided by the Administrator on 3/6/20. The facility failed to ensure assistance was provided with meals to promote nutritional intake for 1 (Resident #60) of 5 (resident #' 17, 59, 60, 63, and 71) sampled residents who required assistance with meals. The failed practice had the potential to affect 14 residents who required assistance with meals per a list provided by the Administrator on 3/6/20 at 8:10 AM. The findings are: Resident # 60 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 1/30/20 documented the resident scored 11 (8 - 12 indicates moderate impairment) on a Brief Interview for Mental Status and required extensive assistance with eating and personal hygiene. a. The resident's Care Plan revised on 8/18/19 documented, . PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on X (times) 1 staff for personal hygiene and oral care . The resident has a swallowing problem r/t (related to) Dysphagia. Resident receives a Pureed diet, tube feeding as ordered . All staff to be informed of resident's special dietary and safety needs . b. On 3/3/20 at 4:46 PM, a telephone interview was conducted with Resident #60's family member who stated that on the resident's recent hospitalization the resident had arrived at the hospital with an unkempt condition. She stated her tongue was white. It looked like it had not been cleaned in a long time. c. On 3/4/20 at 9:46 AM after resident had received morning care, the resident was asked if the staff did oral care, and she stated, They sure don't. d. On 3/5/20 at 11:00 AM, the Activities of Daily Living Charting documented, The resident required extensive to total assistance for personal hygiene which included combing hair, brush teeth, shaving, applying makeup, and washing hands. . Personal hygiene q (every) shift . Under the documentation for meals, the task instructions documented, .Resident to be up for all meals. Take to dining room to be supervised . e. On 3/5/20 at 10:30 AM, the resident was dressed and sitting up in the wheelchair in her room. She was asked, Have you had oral care this morning? She said No. f. On 3/5/20 at 10:46 AM, CNA #2 was asked, When was oral care done on residents? She stated, Every day, every shift I would do it after breakfast. g. On 3/5/20 at 10:49 AM, CNA #3 was asked when oral care was done for the residents who were dependent on staff for oral care and she stated, Every day after meals. h. On 03/05/20 at 1:11 PM, the resident was in bed with a food tray across her lap. She stated, I don't know where that girl went to, she feeds me. Her tray had approximately 1/4 of the meat gone and a few bites of beans were missing. She had two ice creams and a mighty shake on the tray which she could not reach. She stated that her foot hurt and that she had dropped her tea. The glass of tea was in the bed with the resident and some tea was observed spilled on the bed. The resident was asked if she could punch the call button to get assistance, and she did. She was asked if oral care had been done today and she said, No. CNA #5 answered the call. She was asked if the resident could feed herself, and she stated, Yes. The resident stated, Sometimes. (sometimes she could feed herself and sometimes she could not). The CNA then asked the resident was she finished. The resident did not reply. She could not have reached the mighty shake, ice cream or dessert that were on the tray. The CNA then began to offer her bites and she accepted them. She ate about 1/2 of the cup of the strawberry ice cream. She then offered her some cobbler and she ate all of it. The resident then asked for a drink and accepted tea and mighty shake. When the staff handed the resident the mighty shake, she was unable to hold on to it and it dropped in the bed. i. On 3/5/20 at 2:17 PM, Licensed Practical Nurse #1 was asked, Should a resident who is unable or needs assistance with meals be assisted with meals? She said, Yes. She was asked, Should oral care be performed by staff for those who are dependent for oral care? She said, If they are dependent. j. On 3/5/20 at 2:23 PM, the Director of Nurses was asked, Should residents who are dependent on staff for eating be assisted by staff? She said, Yes. She was then asked if residents are dependent on staff for care, should staff assist them daily with oral care? She stated, Yes. k. On 3/5/20 at 4:41 PM the Administrator provided a sheet entitled Activities of Daily Living (ADLs), Supporting which documented, .Residents who are unable to carry out activities of daily living independently will receive the service necessary to maintain good nutrition, grooming and personal and oral hygiene.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure a unavoidable pressure ulcer did not develop for 1 (Resident #64) of 7 (Resident #'s 17, 24, 27, 58, 60, 64, and 71) sampled residents who were at risk for pressure ulcers. This failed practice had the potential to affect 15 residents who were at risk for pressure ulcers based on a list provided by the Nurse Consultant on 3/6/20 at 11/12/20 AM. The findings are: Resident #64 had [DIAGNOSES REDACTED]. The MDS documented his mental status was cognitively impaired. a. The Care Plan dated 02/03/20 documented, The Resident has Stage IV pressure ulcer to Sacrum . has Stage III pressure ulcer rt (right) buttock . has SDTI (Suspected Deep Tissue Injury) to right heel . Administer treatments as ordered and monitor for effectiveness . Avoid positioning the resident on sacrum b. A physician order [REDACTED]. cleanse right lateral lower leg w/wd cleanser. Pat dry w/4x4 gauze. Apply Santyl and cover w/[MEDICATION NAME] 4x4 bordered gauze. c. On 3/05/20 at 1:28 PM, LPN #3 provided wound care to a wound on the right side of Resident #64's leg. d. A skin and wound evaluation dated [DATE] documented, . Pressure-Medical device related pressure ulcer . Deep Tissue Injury . Right Calf . In house acquired . How long has wound been present . New . Wound Measurements: Area 1.1cm (Centimeter) . Length 2.1cm . Width 0.7cm. e. On 3/6/2020 at 7:57 AM, LPN #3 was asked if Resident #64's wound to his right leg was a pressure related wound. She stated, Yes, the previous nurse said it was related to his leg laying on the catheter tubing. f. On 3/6/2020 at 10:51 AM, a phone interview was conducted with LPN #4. She was asked the following questions. Can you tell me about why you documented that Resident #64's ulcer on his right leg came from a medical device? She stated, Well when I noticed where the pressure ulcer was it appeared to be an area where the Foley catheter had been laying under the resident, it was red. She was asked, Was the Foley catheter laying under the resident when you saw the red area? She stated No. She was asked, Who did you report it too? She stated, I'm sure I reported to someone because that is what I do if I notice a new skin issue on a resident. g. On 3/6/2020 at 10:30 AM, the DON was asked, How do you help prevent residents from getting a pressure ulcer? She stated, Hydration, turn every two hours, good peri-care. She was asked, Can you tell me about Resident #64's pressure ulcer to his right leg? She stated, He had pressure ulcers when he came. I think he was admitted to the facility with all the pressure ulcers he's got. He is a very sick man. He was hospitalized for [REDACTED].
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure staff wiped away from the urinary meatus when cleaning the rectum to prevent potential urinary infections for 1 (Resident #59) of 15 (Resident #'s 17, 22, 23, 24, 27, 28, 30, 40, 59, 60, 63, 64, 68, 70, and 288) sampled residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 53 residents who were incontinent and dependent on staff for their care based on a list provided by the Administrator on 3/6/20. The findings are: Resident #59 had a [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/21/20 documented the resident scored 3 (0-7 indicated severe) on a Brief Interview for Mental Status (BIMS) and required extensive assistance for personal hygiene, toilet use and total assistance for bathing. a. A Care Plan revised on 10/21/18 documented, . Check each round for incontinence. Change clothing PRN (as needed) after incontinent episodes . b. On 03/02/20 at 04:42 AM, Certified Nursing Assistant (CNA) #1 began to provide incontinent care. She used wet wipes and wiped down each side of the groin area. She did not separate or clean down the center of the labia. She turned the resident and wiped in a upward stroke from rectum toward the urinary meatus. A small amount of stool smeared onto the wipe. With a second wipe, the CNA wiped up and down across the rectum. c. On 3/5/20 at 2:23 PM, the Director of Nursing was asked if staff should wipe in a front to back motion when doing incontinent care to prevent potential infections, and she stated, Front to back. d. A sheet entitled Perineal Care

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) provided by the Administrator on 3/6/20 at 8:10 AM documented, . Separate labia and wash area downward from front to back . Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a nebulizer bottle was covered when not in use, a water bottle attached to the concentrator was changed when empty, and oxygen setting was on the prescribed flow rate to prevent potential complications for 1 (Resident #58) of 4 (Residents #13, #23, #58, and #84) sampled residents who had an order for [REDACTED].#58 had a [DIAGNOSES REDACTED]. a. A physician order [REDACTED]. OXYGEN 3L/NC (Liter / Nasal Canula) as needed for shortness of breath . b. The care plan with a completion date of 2/03/20 documented, .Oxygen settings: O2 via nasal prongs @ (at) 2L/min (minute): Humidified . c. On 03/2/20 at 7:53 AM, Resident #58 was in bed. The oxygen was on at 2.5 liters by nasal cannula. The humidification bottle attached to concentrator was empty. A nebulizer mask was sitting on top of the oxygen concentrator, not bagged. d. On 3/3/20 at 9:36 AM, Res #58 was in bed with eyes closed, and oxygen on at 2.5 liters by nasal cannula. e. On 3/6/2020 at 10:15 AM, Licensed Practical Nurse (LPN) #3 was asked, Should oxygen be on prescribed dose, water bottle attached to the concentrator be replaced when empty, and nebulizer covered when not in use? She stated, Yes. f. On 3/6/2020 at 10:30 AM, the Director of Nursing (DON) was asked, Should oxygen be on prescribed dose, water bottle attached to the concentrator be replaced when empty, and nebulizer covered when not in use? She stated, Yes. 2. On 3/06/20 at 10:15 AM, the Administrator provided a policy for the Nebulizer titled, .Administering Medications through a Small Volume (Handheld) Nebulizer. It documented, . Store in a plastic bag with the resident's name and the date on it . 3. On 3/06/20 at 11:00 AM, the Administrator provided a policy for oxygen titled, Oxygen Administration. It documented, . Review the physician's orders [REDACTED]. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through . Periodically re-check water level in humidifying jar .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure dirty linens were not placed on the floor to prevent potential for the spread of infections; and failed to ensure staff washed their hands after personal care of one resident and before entering and caring for the needs of another resident to prevent the potential for the spread of pathogens for 1 (Resident #60) of 21 (resident #'s 13,17, 22, 23, 24, 27, 28, 30, 40, 54, 58, 59, 60, 63, 64, 68, 70, 71, 84, 285 and 288) sampled residents who required assistance with personal care. This failed practice had the potential to affect all 87 residents living in the facility based on the Residents Census and Conditions of Residents form. The findings are: 1. Resident # 60 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 1/30/20 documented the resident scored 11 (8 - 12 indicates moderate impairment) on the Brief Interview for Mental Status and required extensive assistance with eating and personal hygiene. a. On 3/3/20 at 10:04 AM, Certified Nursing Assistant (CNA) # 6 was in the resident's room to provide care. The CNA turned the resident over, and the resident's brief was saturated as well as the draw sheet. The aide looked for wipes in the room and did not find any. She removed her gloves and left the room without washing her hands. She returned and without washing her hands, she donned fresh gloves, removed the brief, and began to wipe the resident with wet wipes. She wiped across the resident's abdomen, then down each groin, down center using a different wipe each time. She turned the resident over and there was a small bowel movement. She wiped in an upward motion toward the back until the wipe's came back clean. She then removed the resident's pajamas. She never removed the gloves throughout the care. After removing the resident's clothes, the resident requested a bath. CNA #6 then removed her gloves, covered the resident, and left the room to get supplies. Before leaving the room, she removed the trash that contained the dirty brief. She returned to the room with supplies. She replaced the bag in the trash can and without washing her hands, donned gloves, ran water in the pan and began washing the resident's face. Her pager went off in her pocket. She removed the pager from her pocket without removing her gloves then returned the pager to her pocket and continued bathing the resident without changing her gloves. She bathed the resident and with the same gloves she applied lotion to the resident's feet, arms, chest. She then put the linens in a bag placing the resident's personal sheets in a container for family to pick up. The towels and wash clothes were bagged and placed on the overbed table. She covered the resident with a fresh sheet, and then she removed the gloves. Without washing her hands, she exited the resident's room and placed the bagged towels in a barrel. From there she entered room F3 and began to make up that bed without washing her hands or applying gloves. b. On 3/5/20 at 10:46 AM, CNA # 2 was asked, Where do you place a soiled brief during incontinent care? She stated, Put it in a plastic bag. c. On 3/5/20 at 10:50 AM, CNA # 4 was asked, Where do you place a soiled brief during incontinent care? She stated, Put it in a bag and then take it out to trash. d. On 3/6/20 at 9:16 AM, the Director of Nursing was asked, Should hands be washed after care of a resident, and before caring for another resident? She stated, Yes, ma'am. e. A document entitled, Hand Washing/Hand Hygiene documented, . 7 . b. Before and after direct contact with residents . m. After removing gloves . 9. The use of gloves does not replace hand washing/hand hygiene . 2. On 3/4/20 at 9:49 AM, CNA #6 was in resident's room F9A with the curtains drawn. There were linens on the floor beneath the curtain. CNA #6 removed the linens from the floor and set them on the edge of the bed. 3. On 3/5/20 at 2:17 PM, Licensed Practical Nurse #1 was asked, Should soiled linens or soiled briefs be on the floor? She replied, No ma'am.