STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESTIGE CARE CENTER OF PLATTSMOUTH	**602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference: 175 NAC 12-006.09D2 Based on observations, interviews, and record reviews, the facility failed to ensure treatments were provided in accordance with physicians' orders for 2 (Resident 23 and 25) of 6 sampled residents and facility to identify an open wound for 1 (Resident 20) of 6 sampled residents. The facility had a total census of 83 residents. Findings are: A. Observations on 8/25/20 at 11:40 AM revealed an undated dressing to top (dorsal) of Resident 23's left foot. The area measured approximately 1.5 cm by 1.7 cm with grayish drainage. In an interview on 8/25/20 at 11: 40 AM, Resident 23 reported sometimes staff don't do the treatment. In an interview on 8/25/20 at 11:40 AM, Licensed Practical Nurse A reported not being aware of any treatment orders for area on Resident 23's foot. A review of physician's orders [REDACTED]. Apply daily. A review of Resident 23's 7/2020 Treatment Administration Record revealed an order for [REDACTED]. The treatment was started on 7/6/20 and discontinued on 7/20/20. The treatment was initialed as given 3 times per day on 5 days, 2 times per day on 6 days, and 1 time per day on 1 day. A review of Resident 23's Weekly Wound Evaluation of left dorsal foot dated 8/20/20 identified area as a cigarette burn with a length of 2.2 cm, a width of 1.9 cm, and a depth of .2 cm. The current treatment was listed as Calcium Alginate Ag (a sterile, antimicrobial dressing) and foam dressing with an ordered date of 7/30/20. A review of Resident 23's 7/2020 and 8/2020 Treatment Administration Records did not reveal any orders for treatment of [REDACTED]. A review of a fax that the facility received from the pharmacy on 8/25/20 revealed an order for [REDACTED]. The pharmacy did not put the orders on the Treatment Administration Record and the facility did not have the original order to check the Treatment Administration Record with. B. A review of Resident 25's 8/2020 Treatment administration Record revealed the following order for lower back wound: cleanse with saline, apply duoderm (a wound care dressing) and change every 7 days and as needed. Treatment was scheduled for every Thursday on day shift. Resident 25's Treatment Administration Record was blank for treatment on 8/6/20. EMAR (Electronic Medication Administration Record) notes for 8/13/20 and 8/20/18 stated treatment is to be done wound nurse. In an interview on 8/26/20 at 10:29 AM, Registered Nurse Wound Consultant stated the duoderm on Resident 25's lower back was being used to protect the area. The Registered Nurse Wound Consultant reported that the Registered Nurse Wound Consultant was not changing the duoderm. C. Record review of Resident 22's Order Summary Sheet of active orders printed on 8-24-2020 revealed Resident 22's practitioner order to a right heel ulcer. Observation on 8-24-2020 at 3:47 PM of Resident 22's treatment to the right heel revealed LPN B obtained the required items and entered Resident 22's room and completed the treatment as ordered. Further Observation on 8-24-2020 at 3:47 AM revealed Resident 22 had an open wound to the side of the left great toe. On 8-24-2020 at 3:47 PM an interview was conducted with LPN B. During the interview LPN B reported not being aware of the open area to Resident 22's left side of the foot. Observation on 8-25-2020 at 11:45 AM with LPN B revealed LPN B measured the would size as 4.5 centimeters (cm) by 2.5 cm. On 8-25-2020 at 11:45 AM an interview was conducted with LPN B. During the interview LPN B confirmed being aware of the wound on 8-24-2020 and did not follow up with the practitioner and should have.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D2b Based on record reviews and interview; the facility staff failed to provide pressure ulcer treatments for 1 (Resident 20) of 4 sampled residents. The facility staff identified a census of 83. Findings are: Record review of a Order Summary Report sheet with active orders as of 8-24-2020 revealed Resident 20's practitioner order a treatment to Resident 20's right ischium (by tail bone area) to be completed daily. Record review of Resident 20's Treatment Administration Record (TAR) for August 2020 revealed on 8-08-2020, 8-14-2020, 8-15-2020 and 8-23-2020 Resident 20 was asleep. Record review of Resident 20's progress notes and practitioners orders revealed there was no evidence the facility staff had attempted to complete the treatment through the day or attempt to adjust the schedule time of the treatment to meet Resident 20's needs. On 8-26-2020 at 10:48 AM an interview with the Director of Nursing (DON) confirmed follow up on completing Resident 20's pressure ulcer treatment should have been completed.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference: 175 NAC 12-006.16B Based on record reviews and interviews, the facility failed to ensure accuracy of records related to treatments and medications for 3 (Residents 20, 23, and 25) of 6 sampled residents. The facility had a total census of 83 residents. Findings are: A. A review of Resident 23's 7/2020 Treatment Administration Record revealed an order for [REDACTED]. The treatment was started on 7/6/20 and discontinued on 7/20/20. A review of Resident 23's Weekly Wound Evaluation of left dorsal foot dated 8/20/20 identified area as a cigarette burn with a length of 2.2 cm, a width of 1.9 cm, and a depth of .2 cm. The current treatment was listed as Calcium Alginate Ag (a sterile, antimicrobial dressing) and foam dressing with an ordered date of 7/30/20. A review of Resident 23's 7/2020 and 8/2020 Treatment Administration Records did not reveal any orders for treatment of [REDACTED]. A review of a fax that the facility received from the pharmacy on 8/25/20 revealed an order for [REDACTED]. The pharmacy did not put the orders on the Treatment Administration Record and the facility did not have the original order to check the Treatment Administration Record with. B. A review of Resident 23's physicians' orders revealed an order dated 6/18/20 to hold Calcium Alginate and dressing to right foot. Apply unna boot (a compression dressing made by wrapping layers of gauze around leg and foot) to left leg cover with kerlix (a woven gauze bandage). Change Monday and Thursday. A review of a fax that the facility received from the pharmacy on 8/25/20 revealed an order for [REDACTED]. In an interview on 8/26/20 at 7:20 AM, the Administrator reported orders were being faxed directly to the pharmacy by wound consultant. The pharmacy did not put the orders on the Treatment Administration Record and the facility did not have the original order to check the Treatment Administration Record with. C. A review of Resident 23's 7/2020 Treatment Administration Record revealed no documentation to indicate that Calcium alginate AG treatment to left foot was completed or refused on 4 days during the month. D. A review of Resident 23's 8/2020 Treatment Administration Record for 8/1/20-8/24/20 revealed no documentation to indicate that Calcium Alginate AG treatment to left foot was completed or refused on 4 days during the month. E. A review of Resident 25's 8/2020 Medication Administration Record [REDACTED]. F. A review of Resident 25's 8/2020 Medication Administration Record [REDACTED]. G. A review of Resident 25's 8/2020 Medication Administration Record [REDACTED]. H. In an interview on 8/25/20 between 11:01 AM, the Administrator ad

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

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Director of Nursing confirmed the Medication Administration Record [REDACTED]. I. Record review of Resident 20 Treatment Administration Record (TAR)for July 2020 revealed Resident 20 was to receive a treatment to the lower legs daily. Further review of Resident 20's TAR for July 2020 revealed there were 7 days there was not an indication the treatment was completed. J. Record review of Resident 20's TAR for July 2020 revealed Resident 20 practitioner ordered a ointment to a catheter insertion site to be done daily. Further review of Resident 20's TAR for July 2020 revealed there were 5 days there was not an indication staff had completed the treatment as ordered. K. Record review of Resident TAR for July 2020 revealed Resident 20's practitioner ordered a lotion to the bottom of Resident 20's feet for every shift. Further review of the July 2020 TAR revealed there were 10 areas were there was not an indication the treatment was completed. L. Record review of Resident 20's TAR for August 2020 revealed Resident 20 was to receive a treatment to the right outer knee every evening shift. Further review of Resident 20's August 2020 TAR revealed there were 3 days there was not an indication the treatment had been completed. M. Record review of Resident 20's TAR for August 2020 revealed Resident 20 was to receive a treatment to the right Ischium to be completed daily. Further review of Resident 20's August TAR revealed there were 5 days there was not an indication if the treatment was completed. N. Record review of Resident 20's Order Summary Report of Active Orders as of 8-24-2020 revealed the facility staff were to notify the clinical on call for Resident 20's practitioner if Resident 20 refused cares. Record review of Resident 20's August TAR revealed Resident 20 refused care on 8-02-2020, 8-05-2020 and 8-16-2020. Record review of Resident 20's medical record that included progress notes, practitioner orders and Resident 20's Comprehensive Care Plan revealed there was not evidence in Resident 20's record Resident 20's practitioner was notified of the refusal of care. On 8-26-2020 at 8:10 AM information was provided revealing the practitioner was notified of the refuses through a secured communication application, however, this was not part of the residents record. On 8-26-2020 at 10:48 AM an interview was conducted with the DON and the facility administrator. During the interview, the DON confirmed the July and August TARs were not complete.