STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045471	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIRAM SHADDOX HEALTH AND REHAB	**1100 PINETREE LANE MOUNTAIN HOME, AR 72653**

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 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
Complaint # (AR 076) was substantiated, all or in part, in these findings: Based on observation, record review, and interview, the facility failure to ensure skin issues/ (and or) wounds were assessed, measured weekly and accurately documented, to include the type/stage, measurements and description of the wound, to enable accurate tracking of healing progress or prompt identification of deterioration for 2 (Residents #4 and #5) of 3 (Residents #4, #5 and #6) case mix residents and failed to ensure pressure ulcer treatments were ordered by the physician to promote healing and prevent potential deterioration for 1 (Resident #4) of 3 (Residents #4, #5, and #6) who had a pressure area/injury. This failed practice had the potential to affect 4 residents who had a pressure wound according to a list provided by the Director of Nursing (DON) on 08/05/2020. The findings are: 1. Resident #4 had a [DIAGNOSES REDACTED]. The Admission Minimum Data Set
(MDS) with an Assessment Reference Date (ARD) of 06/26/2020 documented the resident scored 01 (0-7 indicates severely impairment) per a Brief Interview for Mental Status (BIMS), required extensive two-person assistance for bed mobility transfers, toilet use and personal hygiene, extensive one person for dressing and eating, had an indwelling catheter and was occasionally incontinent of bowel and was at risk for pressure ulcers. a. The physician's orders for June and July 2020 did not document any orders for wound care to the Right heel or Coccyx. b. The admission care plan and the revised care plan documented, .The resident has pressure ulcer (L) (Left) buttock, (R) (Right) Heel. Date Initiated: 06/23/2020. . (Resident #4) is at high risk for pressure ulcer Blister to right heel Date Initiated: 06/23/2020 .Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Date Initiated: 06/23/2020 (Resident #4) has potential impairment to skin integrity r/t (related/to) fragile skin Created on: 06/30/2020 .Monitor/document location, size and treatment of [REDACTED]. to MD (Medical Doctor). Created on: 06/30/2020 .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Created on: 06/30/2020 c. The Nursing Admit/Readmit Assessment and Care Plan dated 06/22/2020 at 5:30 p.m. documented, .admitted from Hospital .Skin Integrity .Coccyx Pressure . (no measurements documented) .Details/Comments .Buttocks red open area (L) (left) buttock near coccyx, (R) (right) Heel with Blister/pressure area. Braden Score 17 .15-18 At Risk for skin breakdown. d. The Nursing Skin Observation Daily for Four Days dated 06/23/2020 documented, .Site: Coccyx, Type: redness, (no measurements) Stage: NA .Site: Right Heel, Type: Blister (no measurements) Stage: NA . Notes: Skin as above, will place heel in offloading boot for pressure relief to right heel. [MEDICATION NAME] to coccyx every brief change. e. The Nursing Skin Observation Daily for Four Days dated 06/24/2020 documented, .Notes: No new skin issues. f. The Nursing Skin Observation Daily for Four Days dated 06/25/2020 documented, .Notes: No changes with skin integrity. g. The Nursing Weekly Assessment/Note with Skin Audit dated 06/26/2020 documented, .Skin 1. Resident has one or more skin issues .b. No. Skin Assessment: Indicate any skin concerns. (None documented). h. The Nursing Weekly Assessment/Note with Skin Audit dated 07/03/2020 at 7:00 am documented, .Skin 1. Resident has one or more skin issues: a. Yes .Skin Assessment: Indicate any skin concerns: Site: .Groin, Type: Rash . No documentation noted for Right Heel or coccyx. i. The Nursing Skin Observation Tool dated 07/03/2020 documented, .Observation: Site: .Groin, Type: Rash . No documentation noted for Right Heel or Coccyx. j. The Skin and Wound Evaluation dated 07/07/2020 documented, Type: .Pressure .Stage 2 .Right Heel .In House Acquired .New .Exact date . 07/07/2020 .Length 3.3cm (centimeters), Width 4.3 cm, Depth Not Applicable .Ruptured serum filled blister .Slow to heal: wound healing is slow or stalled but stable, little/no deterioration. .Primary dressing: Foam .Notes: Blister noted to heal, leaking bloody drainage to lateral aspect of the heel. Took off pink foam dressing, clean with n/s (normal saline) and placed a [MEDICATION NAME] border 4x4 foam dressing. Secure with kerlix and tape and replaced offloading boot. . keep offloading boot on at all times while in bed. .Practitioner notified . k. The nurse's note dated 07/08/2020 at 1:00 p.m. documented, .APRN (Advance Practice Register Nurse) .notified this nurse of resident skin changes to sacral area. Upon notification this nurse assessed residents skin conditions. Noted to have 101x (by)10x < (less than) 0.1 purple area with top layer of skin peeled back on multiple spots. Resident has been receiving Laniseptic cream to buttocks every brief change. Resident is non-compliant with turning and repositioning and becomes agitated toward staff for attempting help. .Air Mattress has been on bed ever since admit related to high risk for pressure ulcers. Resident is currently transferred to (Hospital) for continued increase weakness, confusion, abnormal labs and overall decline. Prior to transfer to hospital, area cleaned with normal saline, derm gran b applied, and covered with foam dressing. 2. Resident #5 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 06/25/2020 documented the resident scored 13 (13-15 indicates cognitively intact) per a BIMS, required extensive two plus person assistance for bed mobility, transfer, dressing, toilet use and personal hygiene, extensive one person assist for bathing and locomotion, and was occasionally incontinent of bowel and bladder and was at risk for pressure ulcers/injuries. a. The July Physicians Orders documented, . Left Great Toe-Clean With N/S (normal saline) OR W/C (wound cleanser). Apply Dampened Fluff Gauze To Wound Bed And Cover With Small Dry Dressing, Until Resolved every day shift for OPEN AREA 07/14/2020 .Assess for Pain Check dressing placement Check peri wound for signs and symptoms of infection every shift for WOUND CARE 07/13/2020. b. The record review of the July Treatment Administration Record (TAR) documented, .left great toe clean with n/s or w/c. Apply dampened fluff gauze to wound bed and cover with small dry dressing, until resolved every day shift for OPEN AREA - Order Date - 07/14/2020 1715 (5:15 p.m.) .left great toe clean with n/s or w/c. Apply thin layer of triad. Cut to size calcium alginate ag, then [MEDICATION NAME] border 3x3, until resolved. As needed for if dressing falls off - Order Date - 07/13/2020 0948 (9:48 a.m.) - D/C Date - 07/14/2020 1715 . c. The Care Plan documented, . (Resident #5) has STAGE 3 pressure ulcer left great toe or potential for pressure ulcer development r/t disease process secondary to [MEDICAL CONDITION]. Date Initiated: 07/14/2020 . Administer treatments as ordered and monitor for effectiveness. Date Initiated: 07/14/2020 .Assess/record/monitor wound healing, Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Date Initiated: 07/14/2020 Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage. Date Initiated: 07/14/2020 .Resident is not to wear tight shoes or socks Date Initiated: 07/14/2020 .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate Date Initiated: 07/14/2020. d. On 07/12/2020, the Nursing Weekly Assessment/Note with Skin Audit documented, .Skin Assessment: Indicate any Skin Concerns: Site: left great toe, Type: open area (no measurements documented) Stage: NA (not applicable) e. On 07/15/2020, the Skin and Wound Evaluation documented, .Type: Pressure .Stage: Stage 3: Full-thickness skin loss .Location: Left Foot, 1st Digit .How long has the wound been present? (wound age when first assessed): New .Exact Date: 0714/2020 .Wound Measurements: L (Length) 0.6cm (centimeter) x W (Width) 0.4cm x D (Depth) 0.1cm. .Notes: Area is red, granulation noted at base of wound. Drainage noted, clear/yellow. Toe noted to be red/swollen. Area is at tip of toe. Education: keep loose fit sock on feet, no compression. .Practitioner Notified. . f. On 08/05/2020 at 10:19 a.m., LPN #1 was asked, On the Nursing Admit/Readmit Assessment and Care Plan dated 06/22/2020 for (Resident #4) documented the resident was admitted from the hospital with a pressure ulcer to the Coccyx and a blister/pressure area to the right heel. There were no measurements or wound descriptions done on either, why? She stated, I do the measurements, the floor nurse did the assessment. If the resident is admitted after 3pm, I will do the measurements the next day. She was asked, If a new admit or readmit comes in on Friday after 3pm, their wound/wounds are not going to get measured until Monday? The LPN stated, Yes. She was asked, In the details/comments it states, Buttocks red open area (L) buttock near coccyx, (R) Heel with Blister/pressure area, did the nurse contact the physician for wound care orders? She stated, No, when I looked at the resident's coccyx the next day, I could not find an open area and we do not need an order for [REDACTED]. She was asked, In the notes it documents, Skin as above, will place right heel in off - loading boot for pressure relief to right heel. [MEDICATION NAME] to coccyx every brief change did you call and inform the physician of the resident's coccyx and heel? She stated, No, we have a protocol for blisters on heels, and it's a foam dressing and wrap with kerlix. LPN #1 was asked, Can I get a copy of this protocol? She stated, It's not a protocol, it's a treatment for [REDACTED].#1 was asked, Did you have a physician's order to do that? She stated, No. She was asked, When was the heel dressing changed? She stated, On Monday, Wednesday and Friday. She was asked, If the heel was not being measured, how can you tell if it is getting better or worse? She stated, I can't. She was asked, Where in Point Click care is it documented that the dressing was completed on Monday, Wednesday or Friday? She stated, I was pulled to the COVID Hall and the nurses were supposed to do it. She was asked, Where do you usually document that the wound care was completed? She stated, In the MAR (Medication Administration Record). She was asked, I could not find any wound care orders in the MAR for June or July (2020), was the wound care done? She stated, I cannot tell you that, it was crazy at the facility for a couple of weeks. She was asked, On the Nursing Weekly Assessment/Note with Skin Audit dated 06/26/2020 it was documented, Resident has one or more skin issues and No was checked, and under the skin assessment indicate any skin concerns, there was none documented, why? She stated, I don't know what happened. She was asked, On the Nursing Weekly Assessment/Note with Skin Audit dated 07/03/2020 documented, .Skin 1. Resident has one or more skin issues: a. Yes .It documented under Skin Assessment: Indicate any skin concerns: The Groin was documented, there was no documentation for the Right Heel or coccyx, was the right heel and coccyx healed at this time. She stated, I don't know. She was asked, The Nursing Skin Observation Tool dated 07/03/2020 documented, .Observation: Site: .Groin, Type: Rash . there was no documentation for Right Heel or Coccyx, why? She stated, I don't know. LPN #1 was asked, The Skin and Wound Evaluation dated 07/07/2020 documented, Type: .Pressure .Stage 2 .Right Heel .In House Acquired .New .Exact date .07/07/2020 .Length 3.3cm, Width 4.3 cm, Depth Not Applicable .Ruptured serum filled blister .Slow to heal: wound healing is slow or stalled but stable, little/no deterioration. .Primary dressing: Foam .Notes: Blister noted to heal, leaking bloody drainage to lateral aspect of the heel. Took off pink foam dressing, clean with n/s and placed a [MEDICATION NAME] border 4x4 foam dressing. Secure with kerlix and tape and replaced offloading boot. LPN #1 was asked, Why inhouse acquired? She stated, I put in house since it wasn't assessed since admission. LPN #1 was asked, Is this order in the resident's chart? She stated, No, the APN was the one who informed me of it. She gave me orders and the resident went to the hospital the next day. I forgot to put the orders in the computer. She was asked, What do you do when a pressure area/ulcer is identified? She stated, Assess the skin issue. Document the location, stage, measurements, wound description, the color, if its blanchable, has a temp, notify the MD/APN for treatment orders. She was asked, How about a blister on a heel. She stated, It depends if it's a deep tissue injury purplish in color, if the skin is intact and if it has a temp. If it's a clear fluid filled blister, I would place a foam dressing on it. She was asked, On 07/12/2020 Resident #5's Nursing Weekly Assessment/Note with Skin Audit documented an open area to the left great toe, there was no documentation that the area was measured, described or the MD notified? She stated, They notified me to start orders on the 13th, I don't know what happened that it did not get done. She was asked, Did the wound care get done on July 12th? She stated, I do not know. She was asked, On the 07/15/2020 the Skin and Wound evaluation documented How long has the wound been present (wound age when first assessed): New .Exact Date: 07/14/2020, why? LPN #1 stated, That was my mistake it was identified on 07/12/2020. g. On 08/05/2020 at 10:22 a.m., the DON was asked, When a skin issue is identified, when should it be addressed? She stated, Immediately, the nurse should address it and if wound care orders are needed, they need to notify the MD/APN asap (as soon as possible). The DON was asked, What skin issues should be documented in the skin assessments? She stated, Any Skin issues, wounds or injury should be documented. She was asked, Is it the facilities policy to measure pressure areas/wounds? She stated, Yes. She was asked, How about heel blisters? She stated, Yes. She was asked, What is your policy on addressing skin issues? She stated, The nurse should assess, measure and document any skin issues on admission, when identified, then weekly. The MD/APN should be notified asap for treatment orders, if needed. The skin issue/injury should be classified, described, measured weekly and MD/APN

	should be notified of the weekly wound assessment for wound progress or deterioration. She was asked, How do the nurses know when and how to treat a skin injury/wound/issue? She stated, There will be a physician's order that will appear on the TAR. She was asked, If there is no treatment order, can you prove that the wound treatment was completed? She stated, No. She was asked, Have the nurses been trained on skin/wound assessments, documenting, measuring, monitoring and reporting? The DON stated, Yes during orientation and on the floor. The Wound Care policy provided by the DON on 08/04/2020 at 10:40 p.m. documented, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. .Verify that there is a physician's order for this procedure. .The following information should be recorded in the resident's medical record: .The type of wound care .The date and time the wound care was given .The name and title of the individual performing the wound care. .All assessment data (i.e. (that is), wound bed color, size, drainage, ect. (et cetera)) obtained when inspecting the wound. .Report other information in accordance with facility policy and professional standards of practice.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 the resident's catheter drainage bag did not come into contact with the floor in accordance with facility policy for 1 (Resident #12) of 2 (Resident #9 and #12) sampled residents. This failed practice had the potential to affect 6 residents residing in the facility who had indwelling catheters, according to a list, provided by the Administrator on 08/18/2020. The findings are: Resident #12 had a [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 05/19/2020 documented the resident scored 0 (0-7 indicates severely impaired), per a Brief Interview for Mental Status and has an indwelling catheter and is receiving hospice care. a. A physician order [REDACTED]. Foley - Foley cath (catheter) care q (every) shift and prn (as needed) with soap and water or wipes every shift . b. A care plan with a revision date of 02/19/2020 documented, . has indwelling catheter: . will be / (and or) remain free from catheter-related trauma through review date . c. On 08/18/2020 at 10:17 a.m., Licensed Practical Nurse (LPN) #2 was asked, Should a catheter bag or tubing be on the floor? LPN #2 stated, No. LPN #2 was asked, Why? LPN #2 stated, Same reason, the floor is dirty. d. On 08/18/2020 at 11:45 a.m., Certified Nursing Assistant (CNA) #4 pushed Resident #12 into the hallway to the dining room in a wheelchair. Resident #12's catheter bag was attached underneath the wheelchair and dragging the floor. CNA #4 was asked, Should the catheter bag be touching the floor? CNA #4 stated, No. CNA #4 was asked, Why should it not be touching the floor? CNA #4 stated, I don't know. e. On 08/19/2020 at 1:57 p.m., the Director of Nursing (DON) was asked, Is it appropriate for a catheter bag to be dragging on the ground? The DON stated, No, it is not. The DON was asked, If the bag is dragging on the floor what is the negative consequences it can cause? The DON stated, It's picking up germs from the ground. f. On 08/19/2020 at 2:55 p.m., the Administrator was asked, Is it appropriate for a catheter bag to be dragging on the ground? The Administrator stated, No. g. On 08/18/2020 at 3:20 p.m., the Administrator provided the Policy and Procedure for Catheter Care, Urinary which stated, . 2. Maintain clean technique when handling . b. Be sure the catheter tubing and drainage bag are kept off the floor .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was kept off the floor for 1 (Resident #11) of 2 (Residents #5 and #11) sampled residents who had physician's orders [REDACTED].#11 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set with an Assessment Reference Date of 08/10/2020 documented the resident scored 13 (13-15 indicates cognitively intact) per a Brief Interview of Mental Status and required oxygen therapy. a. A physician's orders [REDACTED]. Oxygen every shift . b. On 08/17/2020 at 11:27 a.m., Resident #11 was sitting in a chair next to Bed B

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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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIRAM SHADDOX HEALTH AND REHAB	**1100 PINETREE LANE MOUNTAIN HOME, AR 72653**

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

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) and receiving oxygen via nasal cannula. The oxygen concentrator was located to the left of Bed A with the tubing laying across the floor from the oxygen concentrator. (Photographs of the oxygen tubing laying across the floor was taken at 12:15 p.m.) c. On 08/18/2020 at 10:11 a.m., Resident #11 was lying in Bed B receiving oxygen via nasal cannula. The oxygen concentrator was to the right of Bed A with the tubing laying across the floor to resident. d. On 08/18/2020 at 10:17 a.m., Licensed Practical Nurse (LPN) #2 was asked, Should oxygen tubing be on floor? LPN #2 stated, No. If I see it, I pick it up. LPN #2 was asked, Why should tubing not be on floor? LPN #2 stated, The floor is dirty, and they could be inhaling some of the stuff on the floor. e. On 08/19/2020 at 9:19 a.m., Resident #11 was lying in Bed B receiving oxygen via nasal cannula. The oxygen concentrator was to the right of Bed A with the tubing laying across floor to the resident. (Photographs of the oxygen tubing and humidifier was taken at this time.) f. On 08/18/2020 at 3:20 p.m., the Administrator provided the Policy and Procedure for Oxygen Administration that did not address tubing contact with the floor. g. On 08/19/2020 at 1:57 p.m., the Director of Nursing (DON) was asked, Should O2 tubing be lying on the floor? The DON stated, No, but some of the resident's take the tubing off themselves and lay it on the bed, chair, etc.