STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265697	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN VALLEY HEALTHCARE CENTER	8575 NORTH GRANBY AVE KANSAS CITY, MO 64154

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 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 observation, interview, and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADL's) received the necessary services to maintain good hygiene when staff failed to provide perineal care for two of 5 sampled residents (Resident #1 and #4) who were dependent on staff to provide incontinent care for urine and bowel in a timely manner; staff also failed to provide baths/showers for five residents (Resident #1, #2, #3, #4, and #5) at least twice weekly. The facility census was 135. 1. Review of the facility's Perineal Care Male & Female policy, revised 9/6/2017, showed: - Provide resident care that meets the psychosocial, physical, and emotional needs and concerns of the residents. - Perineal care is performed on residents who are unable or unwilling to maintain body cleanliness and/or who are incontinent of bowel and bladder; will be care planned for each individual resident to meet his or her specific needs, choice and frequency. - Perineal care will be performed for incontinence of bowel and bladder as needed; minimum of twice per shift for residents wearing incontinent products. - Perineal care includes cleansing of the area of perineum, pubis bone, coccyx area, front genital area and anal area. 2. Review of the facility's Personal Bathing and Shower policy, revised 4/25/2018, showed: - Provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. - Bathing preferences should be care planned including type and schedule with their preferences. - Resident has a right to refuse care, including bathing. 3. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, a federally mandated assessment completed by facility staff, dated 3/13/20, showed: - Cognitively intact. - Extensive assist of staff with all ADL's. - Incontinent of bladder. - Ostomy (artificial opening that diverts bowel externally in a collection pouch). - [DIAGNOSES REDACTED]. Observation on 5/14/20, at 10:30 A.M., showed: - The wound nurse removed urine saturated brief to complete wound dressing change to the resident's coccyx area. - He/she cleaned the coccyx wound, applied wound dressing, and brief. - He/she did not cleanse the resident's perineal area, abdomen, legs, and buttocks that were in contact with urine. During an interview on 5/14/20, at 1:00 P.M. the wound nurse said: - He/she should have cleansed all areas in contact with urine and should have provided complete perineal care. - He/she did not have any wipes or wash clothes in the room to provide the care. During an interview on 5/14/20, at 11:00 A.M., the resident said: - Since his/her relocation to a different hall, the last two weeks he/she is being left saturated in urine for extended periods of time. - Staff do not check on him/her regularly to provide incontinent care. - He/she is concerned his/her wound to his/her coccyx will get worse or infected due to being left in urine for extended periods of time. - He/she is not receiving showers on a regular basis. - He/she would like to get at least 2 showers a week. - There is not enough staff for showers to be completed. Review of the facility's shower sheet schedule showed the resident should receive showers on Tuesday and Fridays. Review of the resident's shower sheets for March, April, and May showed: - 3/11/20 refused shower due to pain in hips and too cold. - 3/29/20 shower completed. - 4/24/20 shower completed. - 5/5/20 refused shower. 4. Review of Resident #4's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment. - Total dependence on staff for ADL's including bathing. - Incontinent of bowel and bladder. - [DIAGNOSES REDACTED].M. the resident in the television room in his/her geri chair. - At 12:15 P.M. the resident left the television room and was taken to the dining room for lunch. - At. 1:50 P.M. Certified Nurse Aide (CNA) B and CNA C transferred the resident from his/her geri chair to his/her bed to perform perineal care. The resident's Hoyer pad, clothing, and brief were saturated with urine. During an interview on 5/14/20, at 2:30 P.M. CNA B said: - Perineal care is provided upon beginning of shift, after lunch, and by the night shift after supper. - Residents who require assistance from two staff, he/she has to find another aide to assist them to transfer and provide perineal care due to only one aide on each hall. Review of the facility's shower sheet schedule showed the resident should receive showers on Wednesday and Saturday. Review of the resident's shower sheets for March, April, and May showed: - 3/2/20, 3/4/20, 3/11/20, 3/18/20 shower completed. - 4/6/20, 4/17/20, 4/23/20 shower completed. - No shower sheets completed for May. 5. Review of Resident #2's quarterly MDS, dated [DATE], showed: - Able to make daily decisions; - Extensive assistance of staff for transfers, bathing, and bed mobility; - Uses wheelchair for mobility; - Limited range of motion to both lower extremities; - Occasionally incontinent of bladder and bowel; Observation and interview on 5/14/20, at 10:44 A.M., showed Resident #2 sitting up on the side of his/her bed and the resident said: -He/she requires assistance for all ADL's including incontinent cares; -He/she seldom gets out of bed due to pain; -He/she has not had a bath or had his/her hair washed in several weeks; -His/her hair appeared tangled, greasy, and the resident was wearing a hat to cover his/her hair; Review of the facility's shower sheet schedule showed the resident should receive showers on Tuesdays and Fridays. Review of the resident's shower sheets for March, April, and May 2020 showed: - 3/6/20 shower completed; - 3/10/20 shower completed; - 3/24/20 shower completed; - 3/31/20 shower completed; - 4/3/20 shower completed; - 4/7/20 shower completed; -4/21/20 shower completed; - No shower sheets completed in May; 6. Review of Resident #3's quarterly MDS, dated [DATE], showed: - Cognitively intact. - Extensive assist of staff with all ADL's. -Indwelling catheter (a tube that drains urine from you bladder into a bag outside your body) and ostomy (a surgically created stoma on the abdomen to allow bodily waste to pass into a bag located on the outside of the body); - [DIAGNOSES REDACTED].M., showed Resident #3 lying in bed and the resident said: -He/she requires assistance for all ADL's including dressing and bathing; -He/she is supposed to have a bed bath three times a week on Monday, Wednesday, and Fridays; -He/she has not had a bath or had his/her hair washed in 3 weeks; -His/her hair appeared oily but combed; Review of the facility's shower sheet schedule showed the resident should receive showers on Tuesdays and Fridays. Review of the resident's shower sheets for March, April, and May 2020 showed: - 3/4/20 shower completed; - 3/12/20 shower completed; - 3/18/20 shower completed; - 3/24/20 shower completed; - 3/30/20 shower completed; - 4/8/20 shower completed; - 4/15/20 shower completed; - 4/22/20 shower completed; - No shower sheets completed in May. 7. Review of Resident #5's quarterly MDS, dated [DATE], showed: - Cognitively intact. - Extensive assist of staff with all ADL's. -Indwelling catheter and Ostomy -[DIAGNOSES REDACTED].M., showed Resident #5 sitting in a wheelchair in his/her room and the resident said: -He/she requires assistance for all ADL's including dressing and bathing; -He/she has not been receiving showers twice a week; Review of the facility's shower sheet schedule showed the resident should receive showers on Mondays and Thursdays. Review of the resident's shower sheets for March, April, and May 2020 showed: - No shower sheets completed in March - 4/27/20 shower refused; - 4/30/20 shower refused; - 5/7/20 shower completed; During an interview on 5/14/20, at 12:07 P.M., CNA D said: -He/she has worked for the facility since October, 2019; -The facility is supposed to have dedicated staff to assist with resident showers; -The facility has been short staffed recently and he/she often provides cares to residents on the 600 hall alone; -He/she is unable to give showers to residents when working alone; During an interview on 5/14/20, at 12:29 P.M., CNA A said: -He/she has worked for the facility since October, 2019 but was previously employed at a sister facility for 9 years; -The facility has been short staffed recently and he/she often is

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) expected to provide assistance to 2 halls of residents; -When assisting this many residents, he/she is unable to provide showers or the care the residents need; During an interview on 5/15/20, at 4:00 P.M., the Director of Nursing (DON) said: - Staff should provide complete perineal care to dependent residents every 2 hours and as needed (PRN). - Residents should not be left soiled in urine or bowel for extended periods of time. - Staff should cleanse all areas in contact with urine and provide complete perineal care. - Staff should follow facility policy when providing perineal care. - Staff should provide showers at least twice a week. - Staff should complete shower sheets after each shower and include any skin issues or concerns. - Staff should offer showers the next day or later in the day when a resident refused. MO 9 & MO 9
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide effective interventions to prevent the development of pressure ulcers (PU) (localized areas of tissue damage or necrosis (death) that develop because of pressure over a bony prominence), for one resident when Resident #2 developed a stage II (Injuries that include partial thickness tissue loss that presents as a shallow open wound or blisters) PU to his/her right (R) intergluteal cleft (the groove between the buttocks that runs from just below the sacrum to the perineum) and to his/her left (L) buttock. Additionally, staff failed to communicate, document, asses, and obtain treatment orders for both newly identified PU's when the new PU's were first identified. The facility census was 135. Review of the facility policy for Skin Care and Wound Management dated 7/1/2016 showed: -The facility staff strives to prevent resident skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident and family or responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment; -Skin care and wound management program includes, but is not limited to: analysis of facility pressure ulcer data for quality improvement opportunities; application of treatment protocols based on clinical best practice standards for promoting wound healing; daily monitoring of existing wounds; identification of residents at risk for development of pressure ulcers; implementation of prevention strategies to decrease the potential for developing pressure ulcers; -The Braden Scale (a tool used to identify risk factors for the development of pressure ulcers) on admission, weekly times three weeks, quarterly and with change of clinical condition to identify risk indicators; -An Admission Observation tool will be completed to identify areas of skin impairment and pre-existing signs; -Identify [DIAGNOSES REDACTED]. Risk factors may include: [MEDICAL CONDITION]; co-morbid conditions or healed pressure ulcers; decreased activity; decreased sensory perception; Diabetes; Friction and shear; increased moisture to skin; medications; infections; -Develop a care plan with individualized interventions to address risk factors; -Communicate risk factors and interventions to the care giving team; -Evaluate for consistent implementation of interventions and effectiveness at clinical meeting; -Modify and document goals and interventions as indicated; -Communicate changes to the care giving team; -Treatment: complete the pressure ulcer documentation and skin impairment documentation forms; review and select the appropriate treatment for [REDACTED]. Review of the facility policy for Wound Care dated 7/1/2016 showed: -Residents/patients admitted with or develop skin integrity issues will received treatment as indicated based on location, stage and drainage; -Pressure Ulcer Stage I: Option 1; Soiled by urine or stool: Cleanse are with wound cleanser or normal saline; Pat the peri-wound skin dry; Apply transparent dressing; Change dressing every 3-4 days or as needed. (PRN) for leaking or dislodgement; Option 2; High Friction Area; heel or elbow: Apple skin protectant and allow to dry; apply daily; Option 3: Apply transparent dressing; Change dressing every 7 days or PRN for leaking or dislodgement; -Pressure Ulcer Stage II: Option 1; Wound bed with no to minimal drainage: Cleanse area with wound cleaner or normal saline; Pat the peri-wound skin dry; Apply hydrogel dressing; Secure with secondary dressing; Change dressing every 3-4 days or PRN for leaking or dislodgement; Option 2; Wound bed with no to minimal drainage: Cleanse area with wound cleaner or normal saline; Pat the peri-wound skin dry; Apply transparent dressing; Change dressing every 3-4 days or PRN for leaking or dislodgement; Review of the facility policy for Monitoring a Wound dated 7/1/2016 showed: -Each resident/patient is evaluated upon admission and weekly thereafter for changes to skin condition. Resident/patient skin condition is also re-evaluated with change in clinical condition, prior to transfer to the hospital and upon return from the hospital; -The Braden Scale (a tool used to identify risk factors for the development of pressure ulcers) on admission, weekly times three weeks, quarterly and with change of clinical condition to identify risk indicators; -Complete an evaluation of current skin condition on admission and weekly thereafter; -Conduct daily rounds to verify the following is present with resident/patient care: Appropriate wound treatments are completed and documented; Assistance with nutrition and fluid intake is occurring; Frequent redistribution off areas of pressure; Resident/patient self-mobility and activity is encouraged; Staff promptly attends to resident/patient requests for toileting; Toileting scheduled are followed: -Review the care plan for resident/patient specific interventions; -Report any new skin impairments to supervisor; -Implement wound treatments as ordered; -Evaluate effectiveness of interventions and modify as indicated; -Communicate any changes to the caregiving staff; -Monitor pressure ulcer daily and document any complications or changes. Monitoring to include, but not limited to: Complications, such as increasing area of tissue ulceration or soft tissue infection; Pain and pain management if indicated; Status of area surrounding ulcer observable without removing dressing; Status of dressing, if present; -Document daily monitoring on the treatment administration record (TAR). Document any complication/changes, as indicated, in the progress notes. Review of Resident #2's face sheet showed: -The Resident was admitted on [DATE] with malignant neoplasm of endometrium (a type [MEDICAL CONDITION] that begins in the lining of the uterus), [MEDICAL CONDITIONS] with exacerbation, diabetes with diabetic [MEDICAL CONDITION] (a type of nerve damage that can occur with diabetes), hypertension, and [MEDICAL CONDITION]. 1. Review of the resident's care plan for skin breakdown, revised on 11/19/19, showed: - Resident at risk for skin integrity issues due to obesity, incontinence, and decreased mobility; - Assess skin weekly with cares' weekly skin assessment; - Monitor, document and report to physician as needed changes in skin status; - Use pressure reduction mattress and cushion for wheelchair; - Requires assistance to turn/reposition at least every 2 hours, more often as needed; - Check resident every 2-3 hours and PRN for incontinent episodes; - Provide incontinence/perineal care after each incontinent episode. Review of Resident #2's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/17/20, showed: - Able to make daily decisions; - Extensive assistance of staff for transfers and bed mobility; - Uses wheelchair for mobility; - Limited range of motion to both lower extremities; - Occasionally incontinent of bladder and bowel; - At risk for pressure ulcers; - No pressure ulcers and no other skin issues. No changes made to the resident's pressure ulcer care plan with the MDS update. Review of the physician orders (POS) for April 2020 showed: -Resident to have weekly head to toe skin assessment completed by licensed nurse. Nurse must completed skin observation tool. Document any new areas on the form and complete a change in condition. Every night shift, every Tuesday, for skin check. Notify MD immediately of any new skin changes/findings and obtain new treatment orders Review of the resident's shower sheets for April 2020, showed: -4/3/20, staff documented Hospice, no skin concerns identified; -4/7/20, staff documented Bed Bath, no skin concerns identified; -4/21/20, staff documented Bed Bath and Red Area to buttocks; the charge nurse signed the shower sheet. Review of the resident's weekly skin observation sheet for April 2020, showed: -4/15/20, the nurse documented that there were no skin conditions or changes, ulcers, or injuries; -4/29/20, the nurse documented that there were no skin conditions or changes, ulcers, or injuries; Review of the nurse's notes from 4/1/20 to 4/30/20, showed: -4/1/20 at 12:45 P.M., Social worker notified AseraCare that bath aides are allowed into facility, however there are guidelines, which social worker went over. -4/15/20 at 5:51 A.M., Weekly skin check completed. See full entry for details; -4/29/20 at 6:12 A.M., Weekly skin check completed. See full entry for details; -4/29/20 at 2:40 P.M., Social worker and resident discussed advance care planning. Resident wants to continue to be a DNR and verified her contact information. He/she picked a temporary cremation facility, which is updated in system. Review of the physician orders (POS) for May 2020 showed: -Resident to have weekly head to toe skin assessment completed by licensed nurse. Nurse must completed skin observation tool. Document any new areas on the form and complete a change in condition. Every night shift, every Tuesday, for skin check. Notify MD immediately of any new skin changes/findings and obtain new treatment orders. Review of the resident's shower sheets for May 2020, showed: - Staff documented no showers provided. Review of the resident's weekly skin observation sheet for May 2020, showed: -Staff documented no weekly skin observations. Review of the nurse's notes from 5/1/20 to 5/14/20, showed the following documentation from the Wound Nurse: -5/14/20 at 2:18 P.M., I was informed by a Certified Nurse's Assistant (CNA) that resident has blisters on her buttocks. Full skin assessment done. On both sides in the groin area still visible old healed problem areas, now clearly healed. No open wound in the groin area noted, some scarring possibly visible due to old healed

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) areas. Two problem areas on the resident's buttocks (left and right) noted. On the left buttock an open area, stage 2, possibly broken blisters. Size 1.6x0.9x0.1 centimeters (cm.). On the right buttock an area with several very small blisters, no open wound visible. Size 2.1x1.1x0.0.cm. Also stage 2. Area of the wounds cleaned thoroughly. A generous amount of skin prep applied, area covered with a bordered foam wound dressing. -5/14/20 at 3:02 P.M., Skin Pressure Grid: New area: yes; Assessment refused: no; Progression: No change; Site details: Left buttock - Pressure: Length = 1.6 cm; Width = 0.9 cm.; Depth: 0.1 cm., - Stage II -5/14/20 at 3:24 P.M., New area: yes; Assessment refused: no; Progression: No change; Site details: Right buttock - Pressure: Length = 2.1 cm; Width = 1.1 cm.; Depth: 0.0 cm., - Stage II Observation and interview on 5/14/20, at 10:44 A.M., showed Resident #2 sitting up on the side of his/her bed and the resident said: -He/she requires assistance for all ADL's including incontinent cares; -He/she seldom gets out of bed due to pain; -He/she has not had a bath or had his/her hair washed in several weeks; -His/her hair appeared tangled, greasy, and the resident was wearing a hat to cover his/her hair; -He/she often has to wait a long time for staff to assist with peri-care after he/she has had an incontinent episode; -He/she began having stinging pain to his/her buttocks last week; -He/she knew that he/she had a pressure sore; -Nursing staff confirmed that he/she had a pressure sore on her buttocks while performing incontinent cares; -Nursing staff have been applying barrier cream to his/her buttocks with incontinent care; -The wound nurse had not visited him/her yet to assess his/her wounds; Interview on 5/14/20, at 10:55 A.M., the Unit Manger said: -He/she is a Registered Nurse and the Unit Manager; -He/she was unaware that Resident #2 had any skin concerns; -He/she will assess the resident's skin Observation and interview on 5/14/20, at 11:00 A.M., the Unit Manager entered the resident's room and they did and said the following: -He/she removed the resident's hat and inspected the resident's scalp; -Two small scabbed areas were observed on the resident left temporal region of his/her scalp; -He/she questioned the resident on when she received her last shower and the resident said that she was unsure of date but acknowledged that it has been some time ago; -He/she assessed the resident's neck, upper extremities, torso, back and lower extremities for any skin concerns; -One small, pea sized, scabbed area found on the residents right, posterior heel with no other skin integrity concerns found on the resident's neck, upper extremities, torso, back or lower extremities; -He/she assisted the resident in lying down, lifting the resident's gown, and assisted the resident in turning from side to side to assess the resident's groin area and buttocks; -The resident's left buttock showed an nickel sized, open area with a pink wound bed and with a scant amount of serosanguineous drainage (a thin, watery, pale red to pink drainage) noted to the resident's incontinent pad; -The resident's right intergluteal cleft (visible border between the eternal rounded protrusions of the buttocks) showed a quarter sized, reddish-brown in color, cluster of blisters without any open area and without any drainage; -The resident said that nursing staff are applying a barrier cream to her wounds; -An open package of Peri-Care skin protectant cream, lying on the resident's table was inspected by the Unit Manager, who said: I think we need something more than barrier cream. -He/she said that he/she would have the Wound Care nurse come and assess the resident's wounds and recommend an appropriate treatment; -He/she said that the facility has had concerns with a staffing shortage recently; During an interview on 5/14/20, at 12:21 P.M., the Certified Medication Technician (CMT) said: -He/she assisted the resident with incontinent cares on 5/13/20, and observed 2 PU to the resident's buttocks, one of which was an open wound; -He/she applied barrier cream to the resident's skin on his/her buttocks; -He/she was not aware that the resident had any skin integrity concerns and that he/she provided care for the resident over the weekend; -The resident told her that the wound care nurse had not been in to see him/her; -Skin integrity issues and wounds are communicated between staff through verbal report but that sometimes it is the residents who communicate this to the staff caring for them; -The facility has had a shortage of staff recently and the facility attempts to fill shifts but sometimes we are stuck short. During an interview on 5/14/20, at 12:29 P.M., the Certified Nurse's Assistant (CNA) A said: -He/she has worked for the facility since October, 2019; -He/she providing cares for the resident today and is aware of only 1 PU to the resident's buttock; -He/she applied barrier cream to the resident's skin after performing incontinence care approximately 30 minutes ago; -He/she first observed the PU approximately 2-3 weeks ago and reported this new skin wound to the nurse on duty; -He/she was not sure which nurse she reported this to or the specific date it was reported; -The facility has been short staffed recently and he/she often is expected to provide assistance to two halls of residents; -When assisting this many residents, he/she is unable to provide showers or the care he/she feels the residents need; During an interview on 5/14/20, at 1:00 P.M., the Wound Nurse said: -He/she began working for the facility in April, 2020; -He/she was not aware of any PU to the resident's buttocks and that no one reported this concern to him/her until approximately 10 minutes ago when he/she was informed by the CMT; -He/she did observe an area of excoriation that looked like a scratch on the resident's buttock approximately 1 weeks ago; -He/she applied Skin Prep (a liquid that when applied to the skin, forms a protective film or barrier) to the resident's buttock to protect the area from further breakdown; -He/she did not document his/her observation or the treatment in the nurse's notes; -He/she should have documented this finding in the nurse's notes and completed a skin grid observation assessment. Observation and interview on 5/14/20, at 1:13 P.M., the Wound Nurse entered the resident's room to perform a skin assessment, and did and said the following: -He/she removed the resident's hat and inspected the resident's scalp; -He/she assessed the resident's neck, upper extremities, torso, groin, back and lower extremities for any skin concerns; -One small, pea sized, scabbed area found on the residents right, posterior heel with no other skin integrity concerns found on the resident's neck, upper extremities, torso, groin, back or lower extremities; -He/she assisted the resident in lying down, lifting the resident's gown, and assisted the resident in turning from side to side to assess the resident's buttocks; -The resident's left buttock showed a 1.6x0.9x0.1 cm. sized, open area with a pink wound bed and with a scant amount of serosanguineous drainage noted to the resident's incontinence bed pad; -The resident's right intergluteal cleft showed a 2.1x1.1x0.0 cm. sized, reddish-brown in color, cluster of blisters without any open area and without any drainage; -The resident said that nursing staff are applying a barrier cream to her wounds with each incontinence episode; -He/she educated the resident on the importance of frequent position changes and using call light to request assistance with peri-care after each incontinence episode; -He/she said he/she would document the wounds in the nurse's notes, notify the physician and the resident's family of the resident's wound; -He/she said usually new wounds are communicated to him/her by staff and the usual protocol would include: a skin assessment with wound measurements, documenting the wound status in wound grid assessment tool in the nurse's notes, considering the appropriate wound treatment, educating the resident and/or family on interventions to reduce pressure, notifying the physician of the wound status and obtaining treatment orders prior to initiating a treatment, adding the resident to the wound treatment list for routine assessments and cares, and discussing the wound status in the interdisciplinary meeting to collaborate on resident care planning and nutritional supplements; - He/she said that he/she was not familiar with the facility policy for wound care and that he/she did not receive an adequate orientation before the former Wound Nurse left the facility; -He/she said that he/she feels that there should be more effective ways to communicate resident changes across facility staff. During an interview on 5/15/20, at 4:00 P.M., the Director of Nursing (DON) said: -Staff should notify the charge nurse immediately of any skin changes or skin integrity issues; -The charge nurse should assess the residents' skin weekly and document their findings weekly; -The charge nurse should notify the Wound Nurse of skin integrity issues or of any new wounds; -The Wound Nurse assesses the residents wound, documents findings, notifies the physician, receives wound treatment orders, and contacts the Wound Clinic as needed; - Wound Nurse should assess the resident with wounds or at risk for developing wounds weekly and as needed; -Staff should follow the facility's wound care policy. MO 7
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff followed their infection control policy to prevent the spread of infection when staff did wash their hands upon entering and exiting a resident's room, before putting on clean gloves, before changing gloves between dirty and clean tasks; staff also failed to use a clean field appropriately during a wound treatment for one of 3 sampled residents (Resident #1). The facility census was 135. 1. Review of the facility's Infection Prevention Program, revised 1/15/20, showed: - Reduce the spread of infectious disease within the facility through implementation of the standard and transmission-based precautions. - Maintain compliance with state and federal regulations in relation to infection prevention. - The facility will utilize current Center for Disease Control and Prevention (CDC) guidelines for infection control monitoring and guidance. - Policies, procedures and aseptic practices are followed by employees in performing procedures and in disinfecting of equipment. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/13/20, showed: - Cognitively intact. - Extensive assist of staff with all ADL's. - Incontinent of bladder. - Ostomy (artificial opening that diverts bowel externally in a collection pouch). - Stage IV pressure ulcer (full thickness tissue loss with

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GARDEN VALLEY HEALTHCARE CENTER	**8575 NORTH GRANBY AVE KANSAS CITY, MO 64154**

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) exposed bone, tendon, or muscle). - [DIAGNOSES REDACTED]. Review of the care plan updated 4/8/20 showed: - Focus: pressure ulcer to sacrum and left heel related to [MEDICAL CONDITION] and osteo[DIAGNOSES REDACTED] (bone infection) which hinders the healing process. - Interventions: Administer treatments as ordered and monitor for effectiveness; assess/record/monitor wound healing every week; pressure relieving mattress on bed/cushion on chair; reeducation when refused wound care; monitor and treat pain prior to treatment; monitor nutritional status; turn and reposition every two hours and as needed (PRN). Observation on 5/14/20, at 10:30 A.M., showed the wound nurse did the following: - Gathered supplies and placed on top of the wound cart without cleaning the cart or using a clean field. - Carried supplies to the resident's room and put them down on the bed side table without cleaning or providing a clean field. - Applied gloves, without washing his/her hands and removed a soiled bandage from the resident's heel wound with scissors and placed the scissors on top of the clean wound supplies, discarded the dirty dressing with same gloves, cleansed the wound with wound cleanser, applied wound dressing with same gloves, and cut the kerlix with the dirty scissors and placed them back on clean wound supplies. - Removed gloves and put on another pair of gloves without washing/sanitizing his/her hands. - Removed urine saturated brief, sacrum dressing, cleansed the wound with wound cleanser, removed gloves and washed hands. - With dirty scissors cut the wound dressing, applied dressing, and placed dirty scissors on the bed side table. - Removed gloves, took dirty scissors and placed on the wound medication cart, with ungloved hands cleaned scissors with sani-wipe and placed back on top of the dirty wound cart. During an interview on 5/14/20, at 12:00 P.M. the wound nurse said: - He/she should have used a clean field on the wound cart and on the bed side table in the resident's room. - He/she should have removed gloves and washed hands between dirty and clean tasks. - He/she should cleanse scissors after each use. - He/she should have removed gloves and washed hands after cleansing wounds. During an interview on 5/15/20, at 4:00 P.M., the Director of Nursing (DON) said: - Staff should follow facility policy when providing wound care. - Staff should use proper hand washing/gloving for wound care. - Staff should use a clean field and clean work area. - Staff should removed gloves and wash/sanitize hands when going from dirty to clean tasks. - Staff should not place dirty or soiled bandages or equipment on clean wound supplies. - Scissors should be cleaned between dirty and clean tasks.