STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48630 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to perform proper incontinent care for 1 (Resident #9) of 1 resident reviewed for incontinent care. Findings include: A review of the Order Summary Report, indicated the facility admitted Resident #9 with diagnoses that included morbid (severe) obesity due to excess calories, dysuria, urinary tract Infection. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2024 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS indicated the resident was substantial/maximal assistance with toileting hygiene. A review of Resident #9's Care Plan, revised 04/19/2024, revealed the resident is at risk for impaired skin integrity r/t (related to) incontinence, impaired mobility, obesity, circulatory issues associated with atherosclerotic heart disease, scoliosis, and DM (diabetes mellitus). Interventions included provide incontinent/peri-care after each incontinent episode and as needed dated 07/09/2019. During an observation on 05/31/2024 at 11:32 AM, Certified Nursing Assistant (CNA) #12 assisted CNA #7 in rolling the resident to a left side lying position. CNA #12 used disposable wipes to clean an incontinent episode from the base of the buttocks near the anus and cleansed upwards. After pausing to ensure all stool was removed CNA #12 noted solid waste below the resident's buttocks, cleansed the area with disposable wipes, and applied barrier cream to the sacrum. A clean brief was placed behind the resident, the resident was rolled onto their back and CNA #12 and #7 secured the brief, repositioned resident, and exited the room. Licensed Practical Nurse (LPN) #10 was present in the room but never advised the CNAs otherwise. Resident #9 was noted to have been incontinent of solid waste, and neither the CNAs or the LPN cleaned the perineal area. During an interview on 05/31/2024 at 01:56 PM, CNA #12 confirmed only the backside was cleaned during the incontinence episode task and the front should have been cleaned as well. CNA #12 said to the Surveyor that by not cleaning the perineal area there was a potential to cause yeast infections or urinary tract infections. (continued on next page)

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.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/31/2024 at 02:30 PM, LPN #10 confirmed incontinent care was only performed from the anus to the rear, and that the front should have been cleaned as well. LPN #10 added that by not cleaning the perineal area the resident was at risk for skin breakdown and urinary tract infections. During an interview on 05/31/2024 at 02:40 PM, the Director of Nursing (DON) stated that incontinent care with stool involved should include cleaning from the top of the buttocks to the thighs, between the thighs, and the front. The DON added this is to ensure that the resident does not endure any skin breakdown or a urinary tract infection from stool entering the urinary tract. A review of a facility policy titled, Perineal Care, dated 2017, indicated, .Using gentle downward strokes, clean from the front to the back of the perineum to prevent intestinal organisms from contaminating [perineal area]. Turn the patient on his/her side to the [left side, left hip and lower extremity straight, and right hip and knee bent] position, if possible, to expose the anal area. Clean, rinse, and dry the anal area, .wiping from front to back. After cleaning the perineum, apply a moisture-barrier skin protectant as needed.

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(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 - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48630 Based on observations, interviews, record review, facility document review, and facility policy review, the facility failed to perform wound care treatments as ordered by the physician to prevent worsening of an identified pressure ulcer for 1 (Resident #465) of 1 resident reviewed for pressure ulcers. Findings include: A review of the Order Summary Report indicated Resident #465 had diagnoses that included immunodeficiency, extended spectrum beta lactamase (ESBL) resistance, peripheral vascular disease, pressure ulcer of sacral region, stage 4, local infection of the skin and subcutaneous tissue, unspecified, pain, unspecified, type 2 diabetes mellitus without complications, and elevated white blood cell count. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/2024, revealed Resident #465 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact, and had one stage 4 pressure ulcer present at time of assessment (Stage 4 pressure ulcers involve full-thickness skin loss that extends through the fascia with considerable tissue loss. There may be muscle, bone, tendon, or joint involvement). A review of Resident #465's Care Plan, revised 03/20/2024, revealed the resident has a pressure ulcer or potential for pressure ulcer development r/t (related to) impairment in mobility, foley catheter tubing, bowel incontinence, anorexia, and protein-calorie malnutrition. Interventions included administering treatments as ordered and observe for effectiveness, dated 11/30/2023. A review of the Order Summary Report, revealed Resident #465 had a physician's order with a start date of 04/16/2024 which stated, Cleanse sacrum with wound cleanser. Pat dry. Apply primary dressing of [named brand of mesh gauze] to the exposed bone. Apply secondary dressing of saline moistened gauze to wound bed. Apply tertiary dressing of 2 ABD (abdominal pad) pads secured with tape daily and PRN (as needed) soiling/saturation every day and evening shift for wound healing. This order was discontinued on 05/07/2024. A review of Treatment Administration Record (TAR) 04/01/2024- 04/30/2024, revealed Resident #465 had wound care treatments scheduled every day and evening shift starting on 04/16/2024 which according to the TAR the treatments were not completed on 04/16/2024 evening shift, 04/19/2024 both day and evening shift, 04/22/2024 evening shift, 04/24/2024 both day and evening shift, 04/26/2024 both day and evening shift, 04/29/2024 evening shift, 04/30/2024 evening shift. This was a total of 10 treatments missed. A review of Treatment Administration Record (TAR), revealed Resident #465 had wound care treatments scheduled every day and evening shift continued into the month of May. According to the TAR ordered treatments were not completed on 05/02/2024 day shift, 05/06/2024 both day and evening shift. This was a total of 3 treatments missed for the month of May. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of [Facility named] Wound Healing Center Progress Note Details, revealed Resident #465 had an encounter in the center on 04/29/2024 during which current measurements at that time were 8.7 cm (centimeter) length, 10.8 cm width, and 6 cm depth and noted the wound is deteriorating. A review of Progress Notes revealed Resident #465 had a progress note documented on 05/06/2024 at 21:00 (09:00 PM) which stated, Resident observed diaphoretic and barely responding. No output observed in catheter throughout 8 hour shift. Vital signs taken BP [blood pressure] 108/46, HR [heart rate] 113, O2 [oxygen] 95%. Assess medical contacted, stated to irrigate catheter, 1000 cc (cubic centimeters) of urine returned, UA [urinalysis] obtained, unable to get blood due to being a hard stick, urine sent to [hospital name] lab. [provider name] notified via access medical. A review of Progress Notes revealed Resident #465 had a progress note documented on 05/07/2024 at 04:17 which stated, attempted to draw blood twice in right ac [antecubital], and right hand. Minimum blood return. Attempts unsuccessful. A review of Progress Notes revealed Resident #465 had a progress note documented on 05/07/2024 at 08:35 which stated, Current vital signs 101/46, 103.2 axillary, 56 [heart reat], 16 [respirations], notified [provider name] order to send to [hospital name] for evaluation and treatment, resident is lethargic and slow to respond to verbal stimuli, notified EMS [Emergency Medical Services] to transport, report called to [nurse's name] at [hospital name], notified [name] who is resident caseworker and guardian she verbalized understanding. A review of [Hospital] Critical Care History and Physical, revealed Resident #465 had been admitted to Intensive Care Unit with sepsis, UTI (urinary tract infection) and sacral decubitus. The Certified Nurse Practitioner (CNP) documented the sacral wound was pink with pale yellow slough, foul odor, and undermining. The sacral wound measured approximately 6 inches by 5 inches by 2 inches (This translates to 15.24 cm by 12.7 cm by 5.08 cm). This note was from 05/07/2024 at 19:23 (07:23 PM). A review of [Hospital] Imaging Services, revealed Resident #465 had an MRI (Magnetic Resonance Imaging) of the pelvis on 05/10/2024 which was compared to the last MRI on 07/16/2022. The current impression is large sacral decubitus ulcer with osteomyelitis of most of the remaining sacrum and the posterior left iliac bone. Findings are worse than on the 2022 study. During an interview on 05/31/2024 at 01:29 PM, the Director of Nursing (DON) said wound treatments would be documented in the Treatment Administration Record (TAR). The DON clarified that the wound center was implemented as an intervention to assist with the sacral wound healing. During an interview on 05/31/2024 at 05:24 PM, Registered Nurse (RN) #13 stated that there is currently no wound care nurse in the facility and so all nurses are responsible for wound treatments ordered by the physician. RN #13 added treatments ordered by the physician is the responsibility of the nurse who is assigned to the resident to complete, to ensure optimal care in the facility for each individual resident. During an interview on 05/31/2024 at 05:32 PM, the Director of Nursing (DON) said floor nurses are responsible for treatments ordered by the physician. The DON confirmed on the TAR empty boxes mean the treatment was not signed off and the DON added, If it's not signed off its not completed. The DON emphasized that the importance of wound care as ordered is to ensure continuity of care and to make sure that physician orders are followed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Pressure Ulcer- Injury Prevention and Management, dated 2022, indicated, The facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/injuries. Interventions for prevention and to promote healing. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.