

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Twelfth Street Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12th Street Mishawaka, IN 46544	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>49994</p> <p>Based on observation, record review, and interview the facility failed to notify the physician for significantly elevated blood glucose levels for 1 of 1 resident reviewed for blood glucose (Resident 45).</p> <p>Finding includes:</p> <p>On 9/23/2024 at 11:06 A.M., a record review was completed for Resident 45. Diagnosis included, but were not limited to: Type 2 diabetes</p> <p>A Physicians' order, dated 7/30/2024, indicated the provider was to be notified if Resident 45's blood glucose levels were below 60 mg/dl or above 400 mg/dL.</p> <p>A review of Resident 45's blood glucose results indicated the record lacked documentation the physician was notified of elevated blood glucose levels above 400 mg/dl for the following dates and times:</p> <ul style="list-style-type: none"> - On 9/13/2024 at 12:33 P.M., Resident 45's blood glucose level was 420n mg/dl. - On 9/15/2024 at 1:08 P.M., the residents blood glucose level was 433 mg/dl. - On 9/20/2024 at 11:41 A.M., the residents blood glucose level was 450 mg/dl and at 5:06 P.M., the residents blood glucose level was 416 mg/dl. <p>During an interview, on 9/23/2024 at 1:37 P.M., the Administrator indicated blood glucose levels that were out of parameters should have been charted in a nursing progress note or the triage book located on the unit.</p> <p>During an interview, on 9/23/2024 at 2:15 PM, the Director of Nursing (DON) indicated Resident 45 switched rooms recently and there were triage binders for each hall. The binder on his previous hall may have contained a notification to the Nurse Practitioner (NP). However, a review of the triage binders on both halls with the DON indicated there were no notes to the NP indicating she was contacted regarding the resident's out of range blood glucose levels.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/24/2024 at 10:21 A.M., RN 5 indicated when a resident's blood glucose was out of range, he notified the doctor and put in a nursing progress note. RN 5 indicated there should have been a note associated with Resident 45's high blood glucose levels above 400 mg/dl, but there was not.</p> <p>A current facility policy, titled Notification of Changes, undated and received from the Administrator on 9/23/2024 at 3:07 P.M., indicated the following: Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the residents (sic) physician; and notifies, consistent with his or her authority, the residents representative when there is a change requiring notification.</p> <p>3.1-5(a)(2)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>44111</p> <p>Based on observation, interview and record review, the facility failed to respond to a resident's grievance requesting services in a timely manner for 1 out of 1 residents reviewed for grievances. (Resident L)</p> <p>Finding includes:</p> <p>During an interview on 9/19/2024 at 2:23 P.M., Resident L indicated no one had done range of motion exercises with him, nor had he received any therapy. He indicated he came to the facility so he could get therapy, and he did ask the Administrator for therapy.</p> <p>A record review was completed, on 9/23/2024 at 2:13 P.M., for Resident L. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, spastic hemiplegia affecting left nondominant side, and colostomy status.</p> <p>A Grievance Form, dated 8/5/2024, indicated Resident L was concerned with the wait time in the morning to get his colostomy bag dumped, and wanting further therapy. The form indicated it was resolved on 8/5/2024 with a response of discussed restorative options upcoming and the Medicaid payer.</p> <p>During an interview on 9/25/2024 at 10:14 A.M., the Director of Rehab indicated she could not evaluate a new admission with straight Medicaid funding for a payer source for rehabilitation services without the permission of the Administrator. She believed the money to pay for skilled services came out of the daily rate Medicaid paid for long term services. She indicated she had been approached by Resident L indicating he wanted therapy. She indicated she had informed the Administrator, after his admission, that Resident L would benefit from therapy.</p> <p>During an interview on 9/27/2024 at 8:55 A.M., the Administrator indicated the facility did not offer a restorative program because she did not have anyone in that position. She indicated if someone came in with Medicaid as their payer source, the facility did not get any reimbursement for the therapy services and the facility had to pay out of pocket. She confirmed there was a resident that had approached her to request therapy services and she had completed a grievance form related to the concern. The Administrator indicated the resident requesting therapy services got around in his motorized wheelchair and went outside and smoked cigarettes.</p> <p>A Physician's Order, dated 9/21/2024, indicated physical therapy three times a week for 12 weeks with skilled therapy services including therapeutic exercises, activities, gait training, group therapy, neuromuscular re-education, patient/caregiver education for the treatment diagnosis of muscle weakness and other abnormalities of gait and mobility.</p> <p>During an interview on 9/27/2024 at 9:49 A.M., the Administrator indicated she gave responses back from a grievance within 5 days. The Administrator gave no explanation as to why the grievance, filed by Resident L on 8/5/2024 was not addressed completely until 9/21/2024 when the resident was evaluated by the therapy department and a physician's order for therapy was received.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/2024 at 10:10 A.M., the Administrator provided a policy titled, Resident and Family Grievances, revised 2/2023, and indicated it was the policy currently used by the facility. The policy indicated .1. The Executive Director has been designated as the Grievance Official. 10. Procedure: d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. i. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgement of complaint/grievance and actively working toward a resolution of that complaint/grievance. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances .</p> <p>3.1-7(2)</p>

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<p>F 0621</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Treat residents equally regarding transfer, discharge, and provision of services for all residents, regardless of payment source</p> <p>44111</p> <p>Based on observation, interview and record review the facility failed to provide equal access to services including specialized rehab to a resident with Medicaid payer source for 1 of 1 resident reviewed for rehab services. (Resident L)</p> <p>Finding includes:</p> <p>During an observation and interview on 9/19/2024 at 2:23 P.M., Resident L indicated no one had completed range of motion exercises with him, nor had he received any therapy. He indicated he came to the facility so he could receive therapy and he had asked for therapy. His left leg was no longer straight, he could not open up his hand and had lost range of motion to his left arm. He had received a soft splint to the left hand prior to his admission to the facility but had to ask for someone to put it on him. In addition, he also had an ankle foot orthosis (AFO) for his left foot but felt it was too tight.</p> <p>A record review was completed on 9/23/2024 at 2:13 P.M., for Resident L. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, spastic hemiplegia affecting left nondominant side, and colostomy status.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 7/1/2024, indicated Resident 37 needed partial/moderate assistance for personnel hygiene, required substantial/maximal assistance for shower/bathing and transfer needs, and had impaired range of motion, on one side of his body, to the left upper and lower extremity.</p> <p>A Baseline Care Plan, dated 6/26/2024, indicated Therapy 1. Physical functional goals b. improve functional status, c. minimize decline, 2. Therapy services a. Physical therapy, b. occupational therapy.</p> <p>A Physician's Order, dated 9/21/2024, indicated physical therapy 3 times a week for 12 weeks with skilled therapy services including therapeutic exercises, activities, gait training, group therapy, neuromuscular re-education, patient/caregiver education for the treatment diagnosis of muscle weakness and other abnormalities of gait and mobility.</p> <p>A Physical Therapy Evaluation and Plan of Treatment, dated 9/21/2024, indicated Reason for Therapy: Clinical Impression/Reason for Skilled Services: Based upon patient's body regions, systems and structures, patient presents with balance deficits, decreased dynamic balance, decreased functional capacity, decreased ROM, strength impairments and pain and in consideration of history, personal factors, and functional limitations documented in this eval summary, patient requires skilled PT services to increase LE ROM and strength, minimize falls, increase functional activity tolerance, improve dynamic balance and facilitate discharge planning, in order to return to prior level of functional abilities. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: falls , further decline in function and immobility.</p> <p>(continued on next page)</p>		

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<p>F 0621</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/25/2024 at 10:14 A.M., the Director of Rehab (DOR) indicated she could not evaluate a new admission with Medicaid as a payer source for rehabilitation services without the permission of the Administrator. The DOR had been approached by Resident L who indicated he wanted therapy. She had informed the Administrator after his admission that she believed Resident 37 would benefit from therapy. The only evaluation she was allowed to complete was the power scooter mobility assessment for safety. The Administrator had approved Resident 37's therapy on 9/21/2024 and he was evaluated and placed on therapy services for physical and occupational therapy. She was not certain if Resident 37 had experienced a decline in mobility since she was not allowed to evaluate him upon his admission. There was no other explanation given by the Rehabilitation Director as to why there was a delay regarding completing an evaluation of Resident 37 for therapy needs since his admission and since he had requested to be evaluated.</p> <p>During an interview on 9/25/2024 at 2:00 P.M., the Business Office Manager (BOM) indicated if a Resident who had Medicaid as a payer source had a physician's order for a therapy assessment, a physician's order for therapy services and there was an indication the resident needed therapy, they would be eligible to receive therapy services.</p> <p>During an interview on 9/26/2024 at 8:55 A.M., the Administrator indicated the facility did not offer a restorative program because she did not have anyone in that position. If a resident was admitted with Medicaid as a payer source, the facility did not receive any reimbursement for therapy services for that resident. She indicated the facility had to pay out of the pocket for the resident's skilled rehabilitation therapy. She confirmed there was a resident that had approached her requesting therapy and she indicated she had addressed the request in on a written grievance. She indicated Resident 37 had not experienced a decline and had not needed therapy services because he got around in his motorized wheelchair and went outside and smoked cigarettes.</p> <p>During an interview on 9/26/2024 at 9:49 A.M., the Administrator indicated Resident L came in at his baseline and the reason she offered him therapy services now was because in talking with the Director of Rehab, she indicated Resident L would benefit from upper body strengthening.</p> <p>During an interview on 9/26/2024 at 9:53 A.M., the DOR indicated therapy department would be working on transfers and overall strengthening. The DOR indicated, he currently needed assistance with transfers.</p> <p>On 9/26/2024 at 9:06 A.M., the Administrator provided a policy titled, Specialized Rehabilitation Services, and indicated the policy was the one currently used by the facility. The policy indicated .5. Specialized rehabilitative services are considered a facility service and included within the scope of facility services; therefore, if services are not enumerated in the State plan, the facility will not charge a Medicaid recipient for specialized rehabilitative services .</p> <p>This citation relates to Complaint IN00443668.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48145</p> <p>Based on record review and interview, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment timely for 2 of 3 residents reviewed for Hospice services. (Residents 16 & 28)</p> <p>Findings include:</p> <p>1. Resident 16's record review was completed on 9/23/2024 at 3:10 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, traumatic brain injury, depression, bipolar disorder and anxiety disorder.</p> <p>Resident 16 had a signed hospice contract, initiated on 3/28/2024.</p> <p>A current Physician's order indicated Resident 16 had been receiving Hospice services since 3/28/2024.</p> <p>A Quarterly MDS assessment, dated 3/19/2024, indicated Resident 16 was not receiving Hospice services.</p> <p>A Significant Change MDS assessment, dated 6/19/2024, indicated the resident was receiving Hospice services.</p> <p>Resident 16's record lacked the documentation a Significant Change MDS had been completed timely after the Physician's order was received on 3/28/2024 for Hospice services.</p> <p>During an interview on 9/24/2024 at 9:50 A.M., the Regional MDS Nurse indicated a Significant Change MDS should be completed within 14 days of the initiation of Hospice services for any resident. She indicated Resident 16 should have had a Significant Change MDS assessment completed 14 days after 3/28/2024.</p> <p>2. Resident 28's record review was completed on 9/24/24 at 9:30 A.M. Diagnoses included, but were not limited to: epilepsy, type 2 diabetes mellitus, Chrohn's disease, dysphagia, spinal stenosis and benign prostatic hyperplasia.</p> <p>Resident 28 had a signed Hospice agreement for Heart to Heart Hospice dated 8/2/2024.</p> <p>A current Physician's order indicated Resident 28 had been receiving Hospice services since 8/12/2024.</p> <p>A Quarterly MDS assessment, dated 6/14/2024, indicated Resident 28 was not receiving Hospice services.</p> <p>A Quarterly MDS assessment, dated 8/16/2024, indicated Resident 28 was receiving Hospice services.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 28's record lacked the documentation a Significant Change MDS assessment had been completed within 14 days from the Hospice order on 8/2/2024.</p> <p>During an interview on 9/24/2024 at 9:50 A.M., the Regional MDS Nurse indicated a Significant Change MDS assessment should be completed within 14 days of any resident starting hospice services. Resident 28 should have had a Significant Change MDS assessment completed 14 days after he was readmitted to the facility on [DATE] with Hospice services. The Regional Nurse indicated the facility does not have a policy for MDS assessments, but they used the RAI (Resident Assessment Instrument) manual.</p> <p>3.1-31(d)(1)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>44111</p> <p>Based on observation, record review and interview, the facility failed to complete and maintain grooming for 3 of 4 residents reviewed for activities of daily living (ADLs). (Residents 15, L and 21)</p> <p>Findings include:</p> <p>1. During an observation and interview on 9/19/2024 at 1:53 P.M., and 9/20/2024 at 1:53 P.M., Resident 15's nails were long with a dark substance under them. He indicated no one had offered to clean or trim his nails.</p> <p>During an observation on 9/23/2024 at 9:14 A.M. and 9/24/2024 at 9:17 A.M., Resident 15's nails were long with a dark substance under them.</p> <p>A record review was completed, on 9/25/2024 at 11:36 A.M., for Resident 15. Diagnoses included, but were not limited to: Parkinson's Disease without dyskinesia, chronic kidney disease stage 3, and chronic embolism and thrombosis of deep veins of right upper extremity.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 8/9/2024, indicated Resident 15 required substantial/maximal assistance for personal hygiene and bathing.</p> <p>A current Care Plan, initiated on 8/1/2024, for activities of daily living indicated Resident 15 had a self-care deficit with shaving, washing his face and hands and combing his hair.</p> <p>A current Care Plan, dated 9/17/2024, indicated Resident 15 often refused to have his nails, beard and hair cut.</p> <p>A Review of the Electronic Medical Record for Resident 15, specifically of the Nursing Progress Notes and the Task section, indicated there was no documentation of any refusals of nail care since his admission.</p> <p>During an interview, on 9/25/2024 at 10:46 A.M., CNA 2 indicated when he provided morning ADL care he assisted with washing of the face, chest, peri care, applied body spray, dressed and brushed their hair. When he provided a shower, he assisted with washing, rinsing, drying, dressing and combing their hair.</p> <p>During an interview on 9/25/2024 at 10:54 A.M., CNA 3 indicated when she completed morning ADL care she assisted with a partial bath unless they wanted a complete bed bath. She then assisted the residents to get dressed and transferred them. If she provided a shower, she started with washing their hair, then worked her way down the body, dried the resident's body, then she applied lotion, deodorant, dressed the resident and dried their hair.</p> <p>During an interview on 9/25/2024 at 11:02 A.M., CNA 4 indicated when she provided morning ADL care she washed their face and under their arms, provided peri care, applied deodorant body spray, dressed and brushed their teeth. If a shower was provided, she washed their body from clean to dirty, dried their body, applied lotion, clothing and if there were any skin issues, she told the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/25/2024 at 11:51 A.M., LPN 13 indicated any resident refusals of ADL care would be entered in the nursing progress notes by the nurse and CNA's documented refusals under the electronic application.</p> <p>2. During an observation and interview on 9/19/2024 at 2:15 P.M., Resident L indicated staff had not offered to shave him. He wanted to grow a mustache and a goatee but wanted the sides/cheek/neck area shaved. He indicated the other day his Dad used the electric shaver but he preferred a closer shave with a razor. His left hand fingers were curled under into a fist and he could not open it unless he opened it with his right hand. Resident L's left arm had limited movement.</p> <p>During an observation and interview on 9/23/2024 at 9:16 A.M., Resident L indicated the Administrator had come into his room this morning and asked if he would like to be shaved and have his nails trimmed .</p> <p>During an observation and interview on 9/23/2024 at 1:32 P.M., he indicated no one had assisted him with shaving or nail care.</p> <p>During an observation and interview, on 9/24/2024 at 9:15 A.M. and 2:00 P.M., Resident L indicated he was not offered a shave and his finger nails were not trimmed yesterday.</p> <p>During an observation and interview on 9/24/2024 at 10:40 A.M., Resident L had increased growth of facial hair on his neck, sides/cheek of his face and a brown substance under his long nails. He indicated no one had offered to assist him with shaving or nail care.</p> <p>A record review was completed, on 9/23/2024 at 2:13 P.M., for Resident L. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, spastic hemiplegia affecting left nondominant side, and colostomy status.</p> <p>An Admission MDS assessment, dated 7/1/2024, indicated he needed partial/moderate assistance for personnel hygiene and he required substantial/maximal assistance for showering and bathing needs.</p> <p>A current Care Plan, initiated on 6/27/2024, titled ADL self care deficit, included interventions for personal hygiene assistance with shaving, washing his face and hands and combing his hair.</p> <p>During an interview on 9/25/2024 at 10:46 A.M., CNA 2 indicated when he performed morning ADL care he assisted with washing of the face, chest, peri area, applied body spray, dressed and brushed their hair. When he provided a shower, he assisted with washing, rinsing, drying, dressing and combing their hair.</p> <p>During an interview on 9/25/2024 at 10:54 A.M., CNA 3 indicated when she provided morning ADL care she assisted with a partial bath unless they wanted a complete bed bath, dressed them and transferred them. If she provided a shower, she started with washing their hair then worked her way down the body, dried the body, applied lotion, deodorant and then dressed and dried their hair.</p> <p>During an interview on 9/25/2024 at 11:02 A.M., CNA 4 indicated when she provided morning ADL care she washed their face, under their arms and their peri area, applied deodorant body spray, dressed and brushed their teeth. If a shower was provided, she washed their body from clean to dirty, dried the body, applied lotion, clothing and if any skin issues were noted, she told the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/25/2024 at 11:51 A.M., LPN 13 indicated any refusals of ADL care would be entered in the nursing progress notes by the nurse and CNA's documented refusals under the electronic application.</p> <p>47419</p> <p>3. During an observation on 9/20/2024 at 9:44 A.M., Resident 21 was found to have long fingernails with a dark brownish-black substance under them.</p> <p>During an observation on 9/23/2024 at 1:21 P.M., Resident 21's fingernails remained long with a dark brownish-black substance under them.</p> <p>A record review for Resident 21 was completed on 9/24/2024 at 2:52 P.M. Diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease and mild intellectual disabilities.</p> <p>A Quarterly Minimum Data Set assessment, dated 7/19/2024, indicated Resident 21's cognition was moderately impaired. There were no behavior concerns and he required partial or moderate assist with showers and set up assist for personal hygiene.</p> <p>A current Care Plan problem, initiated on 7/11/2024, indicated Resident 21 needed staff assist for ADLs and grooming. An intervention indicated the resident required assist of 1 staff member for hygiene and grooming.</p> <p>There was no documentation of Resident 21 had refused any hygiene or grooming assistance.</p> <p>During an interview on 9/25/2024 at 1:58 P.M., CNA 12 indicated when she provided personal care, for bathing or showering, she cleaned the resident from head to toe, assisted with oral care and provided nail care. If the resident refused care, she reported it to the nurse.</p> <p>On 9/25/2024 at 1:26 P.M. the ED provided a current policy, dated February 2023 and titled, Activities of Daily Living (ADLs). The policy included, but was not limited to, . Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; .</p> <p>3.1-38(3)(D)(E)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Twelfth Street Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12th Street Mishawaka, IN 46544	
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>44111</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received adequate treatment and monitoring for a pressure ulcer for 1 out of 3 reviewed for pressure ulcers. (Resident 37)</p> <p>Finding includes:</p> <p>During an interview and observation on 9/19/2024 at 11:04 A.M., Resident 37 indicated he had a sore on the back of his left upper thigh. He told the nurse about it 3-4 weeks ago. The dressing covering the sore came off and he told the nurse and she was going to replace it. He indicated the sore was caused by his wheelchair cushion and they gave me a new cushion. The residents skin was observed and there was a circular crater the size of a nickel with swollen, raised edges and loose skin around the edges. Resident 37 indicated staff placed a patch on the wound every couple of days when he asked for one.</p> <p>During an observation and interview on 9/20/2024 at 9:31 A.M., Resident 37 indicated the facility placed a patch on his wound yesterday around 1 P.M. There was a white dressing undated, no initials and there was visible drainage coming through the dressing.</p> <p>During an interview on 9/23/2024 at 3:07 P.M. Resident 37 indicated the dressing had been changed this morning and when he went to the wound clinic, they placed a new dressing on it.</p> <p>During an interview and observation on 9/24/2024 at 2:04 P.M., Resident 37 indicated no one had changed the wound dressing for the day. The wound was observed to have a gauze with tape over it, undated. He indicated he had to ask for the dressing to be changed but RN 7 changed it every weekend.</p> <p>A record review was completed on 9/24/2024 at 1:30 P.M., for Resident 37. Diagnosis included, but were not limited to: chronic venous hypertension with ulcer of bilateral lower extremity, and peripheral vascular disease.</p> <p>A Significant Minimum Data Set (MDS) assessment, dated 7/31/2024, indicated the resident had normal cognition.</p> <p>A Nursing Progress Note, dated 9/11/2024 at 10:32 A.M., indicated resident had 2 open areas on his posterior left leg, the first area measured 2 cm by 1 cm and the other area measured 1 cm by 1 cm. There was no odor, drainage or warmth of the wounds noted. The Physician, Unit Manager and Optum staff were made aware of the wounds, and nursing continued to monitor the wounds.</p> <p>A Weekly Skin Review, dated 9/13/2024, indicated Resident 37 skin was intact.</p> <p>A Weekly Skin Review, dated 9/20/2024, for Resident 37 indicated Pre-existing open areas to BLE treated by wound clinic and wrapped. Continue with current wound care treatment to back and legs. No new open areas or skin concerns noted.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note from the wound care office, dated 9/16/2024, indicated Patient present for care of wound to posterior leg. He notes it is likely from his wheelchair. He reports soreness. The left thigh measurements 1.5 by 1.7 by 0.1 depth, wound depth full, stage 2. The Assessment & Plan-[no debridement due to tenderness. We will dress with medihoney to help with enzymatic debridement. Follow up in 1-2 weeks. Wound Care Orders: Cleanse with mild soap water, Change Frequency: once daily, Cover with: dry gauze secure with tape.</p> <p>A Progress Note from the wound care office, dated 9/23/2024, indicated Patient presents for follow up to posterior left thigh. Measurement Pre Debridement 1.3 cm by 1.5 cm by 0.1 cm. moderate amount of serosanguineous exudate, Wound Depth: full, stage 2. Measurement Post Debridement: 1.4 by 1.6 by 0.1. The Assessment & Plan-was to continue with medihoney dressings. Follow up in 1 week. Wound Care Orders: Cleanse with soap and water, Change Frequency: once daily, Dressing: Medihoney Gel, Cover with: dry gauze secure with tape. Offloading:cushion/Pressure relief.</p> <p>During an interview on 9/24/2024 at 9:21 A.M., RN 6 indicated Resident 37 did not have any wounds the facility monitored or treated. RN 6 indicated the resident received three different creams: one for his knee pain, Clotrimazole to his knee redness and Cetaphil lotion for his back.</p> <p>During an interview on 9/24/2024 at 11:18 A.M., RN 8 indicated if she found a new open area, she would do an assessment, document the location, measurements, note any drainage and stage the area. Under the assessment tab of the electronic medical record, she would document the wound on a skin weekly review form. She would notify the doctor, family and the manager on duty and then she would complete a risk assessment if it was a pressure area.</p> <p>During an interview and observation, on 9/24/2024 at 2:14 P.M., RN 7 indicated after reviewing his orders he did not have any dressing changes ordered, he used to have a wound treatment but now went to the wound clinic for his lower legs. RN 7 was requested and completed a skin assessment and noted the following area to the back of the upper thigh- a 1.5 centimeters (cm) by 2.0 cm, by 0.1 cm in depth circle with moderate amount of green yellow drainage with erythema (redness) around the area, measuring 3 cm by 4 cm. RN 7 indicated if had possibly been a blister that had popped and he was going to have the wound nurse asses the wound and notify the DON. There was an undated dressing on the wound when RN 7 began his assessment.</p> <p>During an interview on 9/26/2024 at 10:01 A.M., the DON indicated a wound was measured once a week during wound rounds by the wound nurse. Staff documented wounds on the UDS's (Electronic Medical Record) under the assessment tab called Skin Only Evaluation. If a nurse found a wound on a weekly skin assessment, the DON expected the nurse to document the new area, notify the nurse practitioner and obtain an order for treatment of the wound. In addition, a care plan would be initiated after the order for treatment was received.</p> <p>On 9/25/2024 at 9:20 A.M., the Regional Nurse provided a policy titled Notification of Changes, dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated . Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: 3. Circumstances that require a need to alter treatment. This may include: a. New Treatment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/25/2024 at 9:20 A.M., the Regional Nurse provided a policy titled, Skin Assessment, dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated . It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management. The policy includes the following procedural guidelines in performing the full body skin assessment. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury .</p> <p>On 9/26/2024 at 11:12 A.M., the Administrator provided a policy titled, Clean Dressing Change, dated 2021, and indicated the policy was the one currently used by the facility. The policy indicated . It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequently of changes .</p> <p>3.1-40(a)(2)(3)</p>		