STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265571	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ash Grove Healthcare Facility	401 North Medical Drive Ash Grove, MO 65604

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on record review and interview, the facility failed to ensure all residents were treated with respect and dignity when one staff (Certified Nurse Aide (CNA) A) proceeded to give one resident (Resident #1) a shower when the resident resisted and called out and the CNA did not attempt alternate interventions to calm the resident. The facility census is 74. Review of the facility's policy on Resident Rights, updated 10/01/21, showed the following: -Residents have the right to be treated with dignity and respect; -Residents can make their own schedule and participate in activities of their choice; -Residents have the right to reasonable accommodation of needs and preferences. 1. Review of Resident #'1's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic Alzheimer's disease (loss of memory) with late onset. Review of the resident's care plan, begin date of 06/09/22, showed the following information: -Resident needed substantial/dependent assistance with bathing. The resident's family prefers a female only provide the resident showers; -Required substantial assistance with upper body dressing and dependent on lower body dressing; -Required partial assistance with hygiene; -He/she will be involved in the decision-making process for his/her activities of daily living; -He/she wanted to be treated with the same dignity that he/she would be treated in his/her home; -Please respect his/her choices for care and routine; (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident is at risk for pain related to fibromyalgia (widespread muscle pain, accompanied by tiredness, memory and mood issues), aging and decreased mobility; -Resident had diagnoses that included depression (feelings of sadness) and anxiety (feelings of fear, dreads and uneasiness); -Staff to explain to resident what they are doing prior to starting and have patience with resident when providing cares; -If the resident is agitated and it is safe to do so, leave and reapproach the resident later; -Staff to use a calm reassuring approach; -Staff to assess for trigger situations such as pain, personal loss, relocation, conflict, or prior history. (Staff did not indicate the resident was combative during showers or refuses showers on the resident's care plan.) Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/10/24, showed the following: -Severally impaired cognition; -Rejection of care behavior not exhibited; -Required partial assistance with oral and personal hygiene; -Required substantial assistance with dressing the upper body; -Dependent on staff for toileting hygiene, shower, and lower body dressing. Review of the resident's August 2024 bathing assessments showed the following: -On 08/05/24, the resident did not refuse bathing, required partial/moderate assistance; -On 08/08/24, the resident did not refuse bathing, required substantial/maximal assistance; -On 08/12/24, the resident did not refuse bathing, required substantial/maximal assistance; -On 08/15/24, the resident did not refuse bathing, required partial/moderate assistance; -On 08/19/24, the resident did not refuse bathing. Resident was extremely combative to staff and self, causing harm to self. Resident dependent upon staff. Review of the resident's shower sheets, for 08/15/24 to 08/19/24, showed the following: -On 08/15/24, no time listed, CNA A gave the resident a shower and no skin issues noted; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/19/24, no time listed, CNA A gave the resident a shower and noted bruising on both of the resident's hands on the tops and bruising on the underneath of both wrists. Review of the Resident's skin assessments, dated 08/19/24, showed the following: -On 08/19/24, at 9:55 A.M., resident skin intact with no bruising noted (before shower); -On 08/19/24, at 10:30 A.M., small pink area on left shoulder, bruise to left lower forearm that was purple in color and bruises to right lower forearm that were purple in color (after shower). Observations of the facility camera footage, dated 08/19/24, showed the following: -On 08/19/24, at 10:02 A.M., CNA A took the resident by the hand and walked towards the shower room; -About halfway to the shower room, the resident pulled his/her hand away from CNA A; -CNA A took the resident by the arm, put the resident's arm under his/hers, and the resident proceeded to go with CNA A, at 10:03 A.M., -At 10:16 A.M., CNA B stood at the shower door, peeked his/her head in, and then closed the door; -At 10:17 A.M., the Activity Assistant came down the hall and went into the shower room. (CNA A was in the shower room with the resident a total of 14 minutes.) Observation on 08/20/24, at 1:30 P.M., of the resident showed the resident was wearing a long-sleeved shirt and sitting at the table in the dining room. The resident was confused. The resident pulled up his/her sleeve on his/her right arm. His/her arm had two purple bruises present. Observation on 08/22/24, at 9:48 A.M., showed the following: -The resident sat in the dining room of the memory care unit; -The resident had a half dollar size deep purple bruise on his/her left arm with a smaller bruise (size of pencil tip) on the underside; -The resident's right arm had four bruises that were dark purple. Two were on the inner arm were half dollar size and the other two were pencil tip. -The resident also had two additional bruises on his/her left arm. One that was purple/red and about 3 inches across and 1 inch wide and another approximately 1 1/2 inches by 2 inches. During an interview on 08/20/24, at 2:30 P.M., CNA A said the following: -He/she has never had exceptional interactions with the resident; -He/she believed the resident's dementia and trauma got triggered during the incident; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she said there was a lot of yelling no matter how he/she did it; -He/she assisted the resident by putting his/her arm under the resident's arm. The resident did not refuse to go to the shower room. He/she did not tell the resident he/she was going to take him/her for a shower. He/she told the resident they were going to get cleaned up; -Once the resident was in the shower he/she proceeded to remove the resident's shirt. After removing the shirt, he/she went to remove the resident's undergarment and that's when the resident began grabbing and scratching the CNA and him/herself; -He/she removed the resident's undergarment and pants; -He/she got the resident into the shower and the resident began to yell for his/her mom; -The resident screamed and called names. The CNA described it as at a preschool level. He/she said this continued throughout the shower; -The resident resisted throughout the shower; -The resident was very unhappy while getting his/her hair washed; -CNA A turned the chair around towards the wall, so the resident faced the wall, so he/she could stand behind the resident and wash the resident. The resident was still combative, so he/she washed as quickly as possible; -He/she rinsed the resident off and attempted to dry him/her, which was unsuccessful; -The resident grabbed at everything. The CNA held the resident's hands down so he/she wouldn't hurt him/herself. He/she took the resident's hands in his/her hands and said the resident's name to try and get to the resident to stop grabbing and scratching; -He/she proceeded to dry the resident and place a brief and pants on the resident to the knees. He/she had the resident stand to pull everything up and it all went sideways; -He/she went to pull the undergarment over the resident's head and the resident was no cooperative and the undergarment elastic was up against the front of the resident's neck; -He/she tried to get the undergarment back off as the resident as the resident was screaming; -The Activity Assistant knocked on the door; -He/she did not think to get another staff until towards the end; -The resident had been combative during showers in the past, but this was the worst time; -The resident had history of resisting cares; -It would not be appropriate to force a resident to take a shower. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24, at 2:00 P.M., Activity Assistance said the following: -He/she was going back to the memory care unit; -He/she got into the unit and could hear hollering from the shower room; -He/she went into the shower room. CNA A was trying to put the resident's undergarment on him/her and the resident was refusing; -The resident was very upset; -He/she had CNA A step away from the resident and he/she took over. The resident calmed down; -The resident had bruising on his/her right forearm. This bruising was not there when he/she worked on Sunday; -CNA B said CNA A jerked the resident into the shower; -He/she and CNA B went to the Administrator immediately; -When a resident refuses a shower, he/she reapproaches throughout the day and if by the end of the day the resident still refuses, he/she let the nurse know; -It would not be appropriate to take by the arm when resident is refusing and force them to the shower. During interviews on 08/20/24, at 1:21 P.M., and on 08/22/24, at 9:10 A.M., CNA B said the following: -When residents with dementia refuse care, he/she stepped away to give the resident some time, then reapproached. If that doesn't work, he/she will get another staff to assist; -On 08/19/24, CNA A took the resident into the shower; -The resident was refusing to go, but CNA A kept pulling the resident to the shower room; -Once the resident was in the shower, he/she heard the resident screaming through the door shortly after going into the shower room; -He/she opened the door and peeked in and asked CNA A if everything was okay. CNA A said he/she just started the water and that was why the resident was upset; -The screaming and yelling intensified three to four times during the time the resident was in the shower and continued the entire time until Activity Assistant went into the shower room; -When the resident came out of the shower the resident had bruises on both arms and the bruises were not there prior to the resident being taken into the shower; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she told the charge nurse and the Administrator about the incident immediately; -The resident does refuse cares and showers at times; -He/she had given the resident several showers and never had the resident scream like the resident screamed during the shower on the 08/19/24; -He/she tells the resident about the care. If the resident is refusing a shower, he/she tried to get the shower completed as quickly as possible; -If the resident was upset, distressed and yelling, or scratching, he/she would stop and reapproach the resident later. If that didn't work, he/she would someone else to help the resident; -If the resident is refusing and staff continue, it would disrespectful and a dignity issue. During interviews on 08/20/24, at 1:20 P.M., and on 08/22/24, at 9:43 A.M., CNA C said the following: -If a resident refused a shower, the staff should step back and give the resident time to calm down and reapproach; -If staff continue to give a resident a shower and the resident is refusing, it would be disrespectful and possibly abusive; -If staff grab a resident's arms/hands and held them, it would not be appropriate. During an interview on 08/20/24, at 1:35 P.M., CNA D said the following: -When a resident refused a shower, he/she would come back later or send another staff; -Staff should not pull on a resident or force them to take a shower; -It would never be appropriate to force a resident to take a shower. During an interview on 08/22/24, at 10:00 A.M., CNA I said the following: -When residents refuse showers, he/she will leave them alone and then talk to them again later; -He/she asked about three times before getting someone else; -If the resident was already in the shower and refused, he/she would try to complete the shower as quickly as possible; -If a resident is yelling, crying, and in distress, he/she would have someone else come in to give them a shower; -He/she has given the resident a shower, the resident does yell, but he/she tries to give him/her a shower as quickly as possible; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the resident continues to be upset, he/she stepped back and gave the resident a break; -It would be inappropriate and a dignity/respect issue to force a resident to have a shower. During an interview on 08/22/24, at 10:07 A.M., CNA J said the following: -When a resident refused a shower, if they're undressed, he/she would use soft tone and try to proceed with the shower; -If the resident began to get upset more, flailing hands and yelling, he/she would another staff to deescalate; -Residents have the right to refuse. If staff force them, it could be abuse and definitely a dignity and respect issue. During an interview on 08/20/24, at 1:48 P.M., Certified Medication Technician (CMT) E said the following: -When a resident refused a shower, he/she would make the nurse aware; -He/she would leave the resident alone, reassess, and try again; -It is not appropriate to force a resident to take a shower. During an interview on 08/20/24, at 2:13 P.M., Licensed Practical Nurse (LPN) E said the following: -When residents refuse a shower, staff should back off, take some time, and come back later; -If that doesn't work, allow someone else to give the shower; -It is not appropriate to grab a resident and force a resident to take a shower; -He/she was made aware of the incident with the resident by CNA B and the Activity Assistant. They notified him/her right after the incident; -He/she went to the Administrator. During an interview on 08/22/24, at 9:25 A.M., LPN H said the following: -Staff are trained on dementia care; -If a resident refused showers, he/she would talk to the resident and get another staff to take the resident to the shower; -If the resident is being given a shower and they refuse, he/she would expect the staff to stop giving the shower and allow the resident to calm down; -He/she completes the resident's skin assessment weekly and the resident had always been pleasant; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a staff continue giving a shower to a resident when they're yelling, upset, and refusing, it would be disrespectful and a dignity concern. During an interview on 08/22/24, at 10:59 A.M., Registered Nurse (RN) K said the following -If residents refuse showers, he/she expected staff to reapproach; -The resident can be combative and refuses at times; -The resident was good with him/her, it can depend on the day; -If a resident was screaming or yelling during a shower, he/she would expect the staff to let him/her know. There is a call light in the shower room to call for help, or the staff could yell out; -It would be disrespectful and a dignity issue to force a resident to shower. During an interview on 08/22/24. at 12:19 P.M., RN G (MDS Coordinator) said the following: -If a resident is flailing their arms and yelling, staff should get someone else in there to assist; -Staff should stop giving the shower, let the resident calm down and if the behaviors continue, step back; -If staff did not stop giving a resident a shower when a resident was refusing, it would be against the resident's right and a dignity and respect issue; -Staff could use the call light in the shower room to reach out for help; -On 08/19/24, when CNA A was giving the resident shower and the resident was refusing, he/she would have expected CNA A to step back and get another staff; -RN G did a skin assessment on the resident after the shower and there were two bruises on the right arm, some redness on the right shoulder, and one bruise on the left arm. The bruises were purple and appeared fresh. During an interview on 08/20/24, at 3:42 P.M., the Assistant Director of Nursing (ADON) said the following: -On 08/19/24, he/she was in the hallway when CNA B came to him/her and said CNA A had pulled the resident into the shower; -The resident was upset and crying; -CNA B said the resident was upset and the Activity Assistant went into help; -He/she went into speak with the Administrator; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a history of being combative during showers; -If the resident was being combative, or refusing a shower, the staff should not do the shower, and reapproach later; -If the resident was in the shower and scratching and yelling, the staff should stop the shower and get another staff; -CNA A should have stopped when the resident was refusing the shower and got another staff; -It's not appropriate to hold a resident's hands down. During an interview on 08/22/24, at 12:25 P.M., the Director of Nursing (DON) and ADON said the following: -If a resident was refusing a shower, they would expect the staff to tap out and stop the shower; -If the resident resisted before the shower began, they would expect the staff to not take the resident into the shower; -If the resident resisted once in the shower, the staff should get another staff, deescalate, and document; -It's the resident's right to refuse. Staff should tell the nurse and it's care planned; -They would have expected CNA A to step back when the resident was being combative and call for another staff. During interviews on 08/20/24, at 400 P.M. and 5:00 P.M., and on 08/22/24, at 1:45 P.M., Administrator said the following: -If a resident is yelling, screaming during a shower, he/she would expect the staff to step back and stop, explain to the resident what he/she is doing and allow the resident to realign with reality; -Staff can then continue with shower and if resident is still refusing, resident safety, use call light; -If the resident is still distressed after stepping back, they should get another staff for assistance; -If the resident is refusing, yelling out, scratching, and a staff continues this would be against the residents rights and a dignity respect issue; -He/she would've expected CNA A to handle things differently. He should have used the call light or cell phone to get assistance; -The resident had bruises on both arms; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she spoke to CNA A on what happened; -CNA A the resident was trying to hurt his/herself, pulling hair, scratching, and inflicting pain on self; -The bruising on the resident's arms were probably accidental when CNA A was trying to stop the resident from hurting him/herself. MO00240663

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interview and record review, the facility failed to maintain a full accounting and record system of resident trust funds when the facility failed to provide a written statement of each resident's trust fund balance and activity to the the resident and/or his/her responsible party quarterly for three residents (Resident #1, Resident #2 and Resident #3). The facility census was 74. Review of the facility policy titled, Pre-Admissions, dated 2024, showed the following: -The business office will manage the resident trust account (RTA); -A quarterly RTA statement will be provided to the resident or responsible party. 1. Review of Resident #'1's face sheet showed the following: -admitted [DATE]; -Diagnoses included Alzheimer's disease (gradual decline in mental and physical functions); -Resident had a family member listed as guarantor. Review of the resident's Durable Power of Attorney (DPOA), dated 09/03/93, showed the following: -Resident completed a Directive and DPOA on 09/03/93 and appointed a family member after two physician's deem the resident incapacitated; -On 08/04/17, Physician A recommended the Power of Attorney (POA) be invoked; -On 08/08/17, Physician B recommended the Durable Power of Attorney (DPOA) be invoked. Review of the resident's RTA activity, dated 08/06/24 to 10/10/24, showed the following: -The resident's name listed as the receiver, but a location other than the facility; -On 08/06/24, the resident had a balance of $325.00; -On 09/06/24, the resident had a balance of $514.82; -On 10/05/24, the resident had a balance of $325.04. Review showed the facility did not provide a copy of the quarterly account statements provided to the resident or resident representative. During an interview on 10/10/24, at 9:03 A.M., the resident said the following: (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When COVID hit, there was a freeze on things so money accrued and he/she was able to pay for a burial policy; -After paying for the policy, the facility said the resident owed back rent on two different occasions, totaling $1300; -Coming up with that money was a hardship and he/she, nor his/her family, wanted to do this again so they want statements of the account; -He/she hasn't gotten any statements. They are supposed to be sent to his/her family member; -He/she would also like to receive a printed statement; -He/she said his/her family member had not received one in awhile; -He/she knows the facility is supposed to provide a quarterly statement. During an interview on 10/21/24, at 10:25 A.M., the resident's family member said the following: -He/she was supposed to be receiving the resident's statements quarterly; -He/she has received a statement in May 2024 that was for April 2024's account information; -He/she received another statement this month and it was the exact same information received in May 2024; -He/she received a cut off for the resident's insurance in September 2024, and had to call the facility. If he/she received statements, it would help him/her to know what's being paid; -He/she said the resident liked to spend money, and he/she doesn't know what's in the account and how much the resident has to spend since he/she didn't receive statements regularly. During an interview on 10/10/24, at 12:00 P.M., the Business Office Manager (BOM) said the resident has a RTA. The resident and his/her representative both should get quarterly statements. He/she doesn't know when they last received a statement as he/she doesn't have a tracking system of when they're to be mailed, or have been mailed. 2. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included sepsis due to escherichia coli (type of bacteria that can cause blood poisoning when it enters the bloodstream); -Resident has a family member listed as guarantor. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/25/24, showed the resident's cognition in tact. (continued on next page)

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	265571	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ash Grove Healthcare Facility	401 North Medical Drive Ash Grove, MO 65604

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's record showed no power of attorney on file. Review of the resident's RTA, dated 08/06/24 to 10/10/24, showed the following: -The resident's name listed as the receiver: -On 08/06/24, the resident had a balance of $390.80; -On 09/06/24, the resident had a balance of $607.83; -On 10/05/24, the resident had a balance of $272.60. Review showed the facility did not provide a copy of the quarterly account statements provided to the resident or a resident representative. During an interview on 10/10/24, at 9:24 A.M., the resident said the following: -He/she has not received a RTA statement for a while; -He/she used to receive a paper copy of how much was in his/her account. It's been over a year since he/she receive a paper copy; -He/she would like a paper statement of what's in his/her account at least quarterly. During an interview on 10/10/24, at 12:00 P.M., the BOM said the resident has an RTA account and does receive statements, but he/she doesn't know when the resident last received a statement due to not keeping track. 3. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (lung disease that makes it difficult to breath); -Resident is listed as the guarantor. Review of the resident's quarterly MDS, dated [DATE], showed the resident's cognition in tact. Review of the resident's Durable Financial Power of Attorney, dated 11/02/18, showed the appointment of a family member upon completion of the DPOA. Review of the resident's RTA activity, dated 08/06/24 to 10/10/24, showed the following: -The resident's family member's address listed as the receiver; -On 08/06/24, the resident had a balance of $2436.54; (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 09/06/24, the resident had a balance of $2685.45; -On 10/10/24, the resident had a balance of $2466.40. Review showed the facility did not provide a copy of the quarterly account statements provided to the resident or a resident representative. During an interview on 10/10/24, at 9:35 A.M., the resident said the following: -Statements used to be sent to his/her family member, but his/her family member has not been getting them; -He/she would like to receive the statements him/herself at least quarterly. During an interview on 10/10/24, at 12:00 P.M., the BOM said the resident had an RTA account and does receive statements, but he/she doesn't know when the resident last received a statement. 4. During an interview on 10/10/24, at 12:00 P.M., the BOM said the following: -He/she was in charge of the RTAs for each resident that has an RTA; -He/she reconciles the resident accounts monthly to ensure they match; -Statements are supposed to be sent out quarterly, or every 90 days, to the resident or the resident's representative if the resident has a Power of Attorney (POA); -He/she doesn't keep track of when the statements have been sent out and he/she can't say when the last statements have been provided to the resident or representatives. 5. During an interview on 10/10/24, at 12:19 P.M., the Director of Nursing (DON) said the following: -The BOM keeps track of the RTAs; -Either the resident or their representative are supposed to receive statements either monthly or at least quarterly; -He/she doesn't know if residents or they're representatives are receiving quarterly statements. 6. During interviews on 10/10/24, at 12:43 P.M. and 1:21 P.M., the Administrator said the following: -The BOM is responsible for the RTAs; -The BOM deposits reconciles the resident accounts and logs receipts; -The residents know how much money is in their accounts by the statements that go out every quarter; (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she would expect the BOM to send quarterly statements on each RTA account to the resident and/or their representative; -He/she knows the process, but didn't know if the residents received the statement quarterly but have gotten them in the last year. MO00241896

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on record review and interview, the facility failed to provide care per standards of practice when staff failed to complete timely follow-up, assessment, documentation, and monitoring of a bruise discovered on one resident (Resident #2) who took medication to prevent blood clots. The facility census is 74. Review showed the facility did not provide a policy regarding monitoring and documentation of bruises. Review of Drugs.com guidance on Plavix (a medication used to prevent platelets in the blood from sticking together to form an unwanted blood clot that could block an artery), dated 04/22/24, showed the following: -Plavix keeps blood from clotting to prevent unwanted blood clots that can occur with certain heart or blood vessel conditions; -Because of this drug action, Plavix can make it easier for a person to bleed, even from a minor injury;. -Plavix increases your a person's risk of bleeding, which can be severe or life-threatening. 1. Review of Resident #'2's face sheet showed the following: -admitted [DATE]; -Diagnoses included stroke (artery inside the skull becomes blocked by plaque or disease). Review of the resident's care plan, begin date of 04/06/23, showed the following information: -Resident required extensive assistance with dressing; -Resident required partial assistance with toileting and transfers; -Resident at risk for skin breakdown related to decreased mobility and incontinence. (Staff did not care plan in relation to skin monitoring/bruising.) Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/10/24, showed the following: -Cognitively intact; -Resident required partial assistance with toileting hygiene, shower, and upper body dressing; -Resident required substantial assistance with dressing the lower body; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident dependent on staff for toileting hygiene, shower and lower body dressing. Review of the resident's Physician Order Sheet, dated August 2024, showed an order, dated 11/11/23, for Plavix, 75 milligrams (mg) one time per day. Review of the resident's Bathing Assessment, dated 08/10/24, showed staff noted no skin concerns. Review of the resident's Skin Monitoring Shower Sheet, dated 08/14/24, showed staff noted per resident, bruising to the upper left leg in the front and in the bend of the leg. Review of the resident's Bathing Assessment, dated 08/14/24, showed staff noted no skin concerns. Review of the resident's Skin Monitoring Shower Sheet, dated 08/17/24, showed staff noted no bruising. Review of the resident's Bathing Assessments showed the following: -On 08/17/24, staff noted no skin concerns; -On 08/20/24, staff noted no skin concerns. Review of the resident's medical record, dated 08/14/24 to 08/19/24, showed staff did not document an assessment, description, or investigation of the cause of the reported bruise on 08/14/24. Review of the resident's skin assessment dated [DATE], at 11:07 A.M., showed a small quarter size bruise, blue/purple in color, to inner left thigh, several inches below groin area (six days after the original report of the bruise). Observation on 08/22/24, at 9:33 A.M., of the resident showed he/she had a bruise on his/her mid thigh front that was purple and approximately a quarter in size. During an interview on 08/22/24, at 9:25 A.M., Licensed Practical Nurse (LPN) H said the following; -When he/she found a bruise on a resident, he/she asked the resident what happened; -He/she will look at the records to see if the bruise was documented the prior shift; -He/she just took the resident off from the bedpan. The resident did have a bruise on his/her inner left leg, about the size of a quarter, that looks fresh, purple; -When he/she finds a bruise, he/she documents on a skin assessment the location, size and color; -They monitor bruises, especially when residents are on blood thinners and have medical issues. During an interview on 08/20/24, at 12:38 P.M., LPN M said he/she was not aware of any bruising on the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24, at 2:13 P.M., LPN F said when he/she finds a new skin area, he/she notifies the Director of Nursing (DON) and followed his/her direction. During an interview on 08/22/24, at 10:59 A.M., Registered Nurse (RN) K said the following: -If he/she or the staff find bruises, they would ask the resident, if they're cognitively intact, what happened; -When find bruising, a skin assessment is completed and that's documented in the computer; -Bruising is documented on the skin assessments or nurse's notes. Staff document the size, location, and color; -Staff follow up each week to monitor. During an interview on 08/22/24, at 12:19 P.M., RN G (MDS Coordinator) said the following: -When bruises are found on residents, staff should ensure the charge nurse knows about the bruise; -Some residents bruise easily; -Staff are to determine what caused the bruising and visit with the resident; -Bruises should be documented on the skin assessments and/or the nurses' notes; -Staff should document size, color, and location; -Bruising and skin issues are monitored weekly on the skin assessments; -If the bruising is found by the shower aide, the aide should document, but also tell the nurse so the nurse could look at the bruise. During an interview on 08/22/24, at 12:25 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said the following: -Staff complete a shower sheet for each resident and they should be documenting all skin issues; -When aides find bruises, they should be notifying the charge nurse; -Then staff will try to find the root cause of the bruise and will interview the resident; -Skin issues are tracked by the skin assessments. They're to document the location, size and color. During an interview on 08/20/24, at 10:22 A.M., 10:40 A.M., and 10:59 A.M., the DON said the following: -When there is a new skin issue found by aides, or documented on a shower sheet, staff should document any new concerns and this is turned into the nurse; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses should look at the skin and see if there needs to be new orders implemented; -The resident has a quarter size bruise on the inner left, front leg that's few inches below the belly. During an interview on 08/20/24, at 10:33 A.M., the Administrator said he/she was not aware of the resident having any bruising. During an interview on 08/22/24, at 1:45 P.M., the Administrator said the following: -He/she would expect staff to report any new bruising to the charge nurse; -Staff are to document any skin concerns on shower sheets and let the nurse know; -The shower sheets go to the nurses to be signed off and they document on the bottom any comments and if it needed treatment; -He/she tried to find the origin of the bruise or reasonable cause if resident couldn't' tell staff; -Weekly skin assessments are completed and any issues brought to RN G, the wound nurse; -If nurses find the bruise they should be documenting the bruise on the skin assessment or progress notes; -He would expect staff to look into the bruise and document; -If staff can't ascertain where the bruise came from, they should let DON and nurse manager know. MO00240663