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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285268 | A. Building<br>B. Wing | 11/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brookestone of Papillion | 610 South Polk Street<br>Papillion, NE 68046 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49164<br><br>Licensure Reference Number 175 NAC 12.006.09(H)(iii)(2)<br><br>Based on observation, interview, and record review; the facility failed to follow practitioner's orders for wound care for 2 (Residents 2 and 3) of 4 residents sampled. The facility census was 92.<br><br>The findings are:<br><br>A.<br><br>Record review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 10-05-2024 revealed the facility staff assessed the following about the resident:<br><br>-Brief Interview of Mental Status (BIMS) score of 15. According to the MDS Manual a score of 13 to 15 indicate a person is cognitively intact.<br><br>-had abdominal hernia surgery,<br><br>-had a surgical wound,<br><br>-was receiving surgical wound treatments.<br><br>Record review of Resident 2's Electronic Health Record (EHR) revealed an order for a wet to dry dressing (a wound dressing that is applied wet and allowed to dry before removal) to abdominal wound daily.<br><br>An observation of wound care was conducted on 11-19-2024 at 12:15 PM of the facility Wound Nurse (WN) performing a wet to dry dressing change for Resident 2. WN lifted Resident 2's shirt to reveal a transparent dressing covering a gauze dressing dated 11-18-2024. WN removed the transparent dressing and then removed the gauze dressing that was inside the wound bed. The gauze dressing was a dull yellow color.<br><br>During the wound care observation on 11-19-2024 at 12:15 PM an interview was conducted with the WN, which revealed the gauze removed from the wound bed was moist and not dry.<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with WN on 11-19-2024 at 12:45 PM confirmed the practitioner's orders were for a wet to dry dressing to the abdomen. Furthermore, WN confirmed the transparent dressing did not allow the gauze to dry, therefore was not a wet to dry dressing.<br><br>B.<br><br>Record review of Resident 3's MDS dated [DATE] revealed the facility staff assessed the following about the resident:<br><br>-BIMS score of 15 indicating a person is cognitively intact,<br><br>-required maximal assistance with personal hygiene, bed mobility, and lower body dressing,<br><br>-required total assistance with transfers,<br><br>-had a fracture,<br><br>-had a surgical wound.<br><br>Record review of Resident 3's Medication Administration Record (MAR) printed on 11-19-2024 revealed an order for treatment to the left pelvis as follows:<br><br>Left pelvis: cleanse with facility cleanser, pat dry, apply xeroform to slough area (cut to fit size of area), cover with an Abdominal (ABD) dressing and secure with paper tape. Change daily and as needed for surgical site.<br><br>Record review of an evaluation of the wound conducted by a Nurse Practitioner dated 10-29-2024 revealed an order for the left pelvis as follows:<br><br>-Wash with facility wound cleanser, pat dry.<br><br>-Paint periwound (skin around the wound) with skin prep and allow to dry.<br><br>-Cover with ABD and or gauze pads for drainage and secure with tape.<br><br>-Change daily and as needed.<br><br>Record review of the facility policy Non-Pressure Skin Conditions revealed once a non-pressure skin change has been identified ongoing monitoring, treatment, and a documentation plan will be initiated.<br><br>The treatment plan related to non-pressure skin changes will be specific for each individual resident as directed by the practitioner and documented on the resident's treatment sheet.<br><br>An interview with Nurse Supervisor (NS) on 11-19-2024 at 3:00 PM confirmed the step in the wound treatment, Paint periwound with skin prep and allow to dry was not on the MAR and staff wound not have known to do it. The NS further confirmed the omission was a transcription error. |