STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045275	A. BUILDING _____ B. WING _____	04/23/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACE POINT, LLC	1700 EAST SHORT HILLSBORO EL DORADO, AR 71730

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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** Complaint # (AR 279) was substantiated, all or in part, with these findings. Based on observation and record review, the facility failed to ensure treatment and care were provided in accordance with professional standards of practice, as evidenced by failure to ensure the catheter was secured at the urethra when cleaning, to prevent potential trauma to the meatus or bladder; failure to ensure the catheter, urethral meatus and surrounding area were thoroughly cleaned of discharge and fecal material to prevent potential infection; and failure to replace a urinary catheter securement device (leg strap) when it was soiled with fecal material, to prevent potential skin irritation, odors, or infection for 1 (Resident #1) of 2 (Residents #1 and #2) case mix residents who had an indwelling urinary catheter. This failed practice had the potential to affect 7 residents who had indwelling urinary catheters, according to the Resident Census and Conditions of Residents form dated 4/23/18. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 3/30/18 documented the resident had severely impaired cognitive skills for daily decision-making per a Staff Assessment for Mental Status, was totally dependent for incontinent care, had an indwelling urinary catheter, and had a Stage IV pressure ulcer. a. A physician's orders [REDACTED].Foley Catheter care Q (every) shift . Clean foley and peri area with soap and H2O (water) Q (every) shift . DX (Diagnosis) . Retention of Urine . b. A Care Plan with a revised date of 4/3/18 documented, .keep clean, dry, and odor free . apply barrier cream PRN (as needed) . NSG (Nursing) staff to provide all ADL (activities of daily living) care to ensure daily needs are met . (Resident) has a urinary catheter related to urine retention and multiple pressure ulcers . Provide catheter care per policy . keep catheter tubing fee of kinks . Change drainage bag per policy . Change catheter per policy . report any changes in bladder status to nurse . prevent tension on urinary meatus from catheter . The Care Plan did not address the need for a leg strap to be placed or checked. c. On 4/18/18 at 2:00 p.m., the resident was lying in bed toward her right side. The dressing to the coccyx area was soiled with brown / green bowel movement, and the leg strap securing the urinary catheter to the resident's right thigh was visibly soiled with feces. d. On 4/19/18 at 3:00 p.m., the resident was in bed, with an indwelling urinary catheter in place. Licensed Practical Nurse (LPN) #1, LPN #3 and Certified Nursing Assistant (CNA) #1 entered the room to provide wound care and urinary catheter care for the resident. The leg strap securing the urinary catheter tubing to the resident's thigh was visibly soiled with feces. After the wound care and catheter care were provided, the staff left the resident's room and left the feces-soiled leg strap on the resident's leg. e. On 4/19/18 at 3:25 p.m., CNA #1 provided catheter care. Without holding the catheter tubing at the meatus, she used a wipe and wiped down the tubing away from the peri area. She performed the same technique again. She was asked to let this surveyor see the 2nd wipe she used to clean the catheter tubing. The wipe had a brown and red substance on it. She did not wipe the tubing again until a wipe appeared free of red and brown substances. She did not open the resident's labia area and cleanse it. The resident was reddened in her upper thighs. CNA #1 was asked, what is that brown and red substance on the urinary catheter tubing? She stated, She's irritated down there, and stool from the bag leaking. LPN #1 applied laniderm to the resident's thighs.
F 0690 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 279) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure the necessary assessments, monitoring, treatment and services were provided for the management of bowel incontinence for Resident #1, as evidenced by: failure to ensure that before a rectal tube with fecal bag (Flexi-seal system) was initiated, the staff responsible for managing the device were knowledgeable and fully competent with doing so; failure to ensure nursing staff monitored the Flexi-seal system and fecal output, promptly addressed leakage of fecal material, kinks or blockage of the tubing, evaluated the positioning of the rectal tube for correct positioning in the rectum when the system continued to experience leakage of fecal material on an ongoing basis, and consulted the physician when the Flexi-seal system continued to be unsuccessful in preventing a Stage IV pressure ulcer from being repeatedly contaminated with fecal material, to prevent further infection and / or exacerbation of the pressure ulcer; and, failure to ensure all nursing staff involved with the resident's care were aware of when to change the Flexi-seal bag and who was responsible for doing so, to ensure fecal material could evacuate from the bowel into the collection bag without impediment for 1 (Resident #1) of 1 case mix resident who had a Flexi-seal system in place. These failed practices resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Resident #1, who had a large Stage 4 pressure ulcer to the coccyx that deteriorated, developed maceration of the surrounding tissue. The failed practices also had the potential to cause more than minimal harm for 4 residents who had pressure ulcers, according to a list provided by the Administrator on 4/23/18. The Administrator and the Director of Nursing were informed of the Immediate Jeopardy condition on 4/20/18 at 4:10 p.m. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 3/30/18 documented the resident had severely impaired cognitive skills for daily decision-making per a Staff Assessment for Mental Status, was totally dependent for personal hygiene, had a feeding tube, was incontinent of bowel and had an indwelling urinary catheter, was at risk for the development of pressure ulcers, had a Stage 1 or higher pressure ulcer, had a Stage IV pressure ulcer measuring 3.0 cm (centimeters) (length) by 2.7 cm (width) by 1.2 cm (depth with slough, required pressure ulcer care, and required pressure reducing device for chair. a. A Hospital Progress Note dated 1/20/18 documented, .Admit 1/13/18 . Subjective . she came in with elevated white blood cell count of 27,000 . She has positive urine culture that grew Proteus Mirabilis . Her wound culture grew Providencis stuartii. She is on [MEDICATION NAME] and Meropenem for UTI (Urinary Tract Infection) and the wound . The hospital documentation indicated the resident was admitted to the hospital on [DATE] and discharged on [DATE]. b. The monthly Wound Clinic Notes dated 1/29/18 documented, .(length) 3 cm (centimeters) (by) (width) 3.2 cm (by) (depth)

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

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F 0690 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) 0.6 cm, area 7.54 cm, volume 4.524 cm, 0% tunneling or undermining and the peri wound had no abnormalities . c. A Hospital Antimicrobial Susceptibility and Organism Identification Report dated admit 1/29/18, discharged [DATE], documented, . CULT (culture) Wound (and) Gram Stain . Identity . Proteus mirabilis . d. A Physician's Telephone Order dated 2/1/18 documented, .[MEDICATION NAME] 825/125 mg (milligrams) one tab BID (twice daily) (times) 10 days for wound . e. The facility's Weekly Wound Assessments documented the following: .2/13/18 .(length) 3.0 cm (centimeters) (by) (width) 2.5 cm (by) (depth) 1.5 cm . peri wound clear . moderate amount serosanguinous exudate . no odor . Specific wound dressing challenges . urine /fecal incontinence soils dressing intermittently . .2/19/18 . (length) 2.9 cm (by) width) 2.6 cm (by) (depth) 1 cm and tunneling at 1.2 cm at 10 o'clock and peri wound denuded . moderate amount serosanguinous exudate . no odor . Specific wound dressing challenges . urine /fecal incontinence soils dressing intermittently . .2/26/18 . (length) 3.0 cm (by) (width) 2.9 cm (by) (depth) 0.5 cm and 10 o'clock tunneling . peri wound the same . moderate amount serosanguinous exudate . no odor . Specific wound dressing challenges . urine /fecal incontinence soils dressing intermittently . The Monthly Wound Clinic Notes for the same date documented, .(length) 3 cm (by) (width) 2.9 cm (by) (depth) 0.5 cm, area 6.833 cm, volume 3.416 cm, 0% tunneling and undermining and the peri wound has scarring . moderate amount serosanguinous exudate . no odor . Specific wound dressing challenges . urine /fecal incontinence soils dressing intermittently . The area of the pressure ulcer had decreased by 0.7 cm from the previous month, and the volume had decreased by 1.108 cm. .3/5/18 . (length) 3.0 cm (by) (length) 3.1 cm (by) (depth) 0.6 cm . 0.5 cm at 10 o'clock tunneling . moderate amount serosanguinous exudate . no odor . Specific wound dressing challenges . urine /fecal incontinence soils dressing intermittently . .3/12/18 . (length) 3.0 cm (by) (width) 3.4 cm (by) (depth) 1.9 cm . 0.5 cm at 10 o'clock and 1.3 cm at 3 o'clock tunneling . peri wound macerated, [DIAGNOSES REDACTED]tous . peri wound open . moderate amount serosanguinous exudate . no odor . Specific wound dressing challenges . urine /fecal incontinence soils dressing intermittently . .3/19/18 . (length) 3.0 cm (by) (width) 3.2 cm (by) (depth) 1.4 cm . 1 cm at 10 o'clock tunneling . peri wound same . moderate amount serosanguinous exudate . no odor . Specific wound dressing challenges . urine /fecal incontinence soils dressing intermittently . f. A Physician's Telephone order dated 3/23/18 documented, .T.O. (Telephone Order) flex seal per rectum. RE (regarding) wound healing . The Flexi-seal manufacturer's instructions, obtained from the manufacturer's website, documented, .Is designed for managing acute fecal incontinence and is not indicated for chronic incontinence . When fecal incontinence with liquid stool is present, the patient will receive anti-diarrhea therapy . 5 Small amounts of moisture or seepage around the catheter is anticipated.Sometimes during the course of using Flexi-seal, the retention balloon may slide deeper inside the rectum and no longer provide an effective seal, thus leaking feces around the catheter. Alternatively, in a patient with a weak rectal sphincter, the balloon may slide out and also lead to leakage 6. How can leakage be prevented? . The best way to prevent leakage is to ensure that the retention balloon is adequately inflated and properly positioned in the rectum at all times during the flexi-seal. make sure that all the instructions for proper insertion are followed. After ensuring that the balloon is properly positioned, take note of the position indicator line relative to the patient's anus. Observe changes in the location of the position indicator line to determine movement of the balloon in the rectum. If the position indicator line moves up (i.e. (such as) closer to the anus), this may indicate that there is a need for gently pulling the catheter to bring the balloon where it should be. If the position indicator line moves down (i.e. away from the anus), this may indicate that the device may expel. In such cases, the balloon should be deflated, removed and re-inserted . 7.Proper positioning, and maintenance of proper positioning, of the retention balloon are key to prevention of expulsion. Maintenance of proper positioning can be achieved by observing changes in the location of the position indicator line to determine movement of the balloon in the rectum.9.Ensure unobstructed flow of stool through the catheter into the collection bag. If the catheter becomes blocked with solid particles, it can be rinsed with water .periodically, 'milk' the catheter to facilitate the flow. Change the collection bag frequently, or before it becomes too full . we recommend changing the bag between 600 ml (milliliters) and 800 ml 10. Can flex-seal be used for formed stool? . No, it cannot. Formed stool cannot pass through the catheter and will obstruct the opening . g. A monthly Wound Clinic Note dated 3/26/18 (3 days after the rectal tube was initiated) documented, .wound measured (length) 3.1 cm (increase of 0.1 cm from previous month's measurement) (by) (width) 2.6 cm (by) (depth) 0.7 cm (increase of 0.2 cm from previous month's measurement), area 6.33 cm upper, and 4.431 cm lower, volume 3 cm . There is no tunneling, or undermining noted. The peri wound skin appearance exhibited excoriation, scarring, maceration . This was the first documented reference in the Wound Clinic Notes regarding the skin surrounding the pressure ulcer being excoriated and macerated. h. The facility's Weekly Wound Assessments documented the following: .3/26/18 . (length) 2.9 cm (by) (width) 3.2 cm (by) (depth) 1.2 cm . 1.0 cm tunneling at 10 to 11 o'clock . peri wound same . .4/2/18 . (length) 3.0 cm (by) (width) 2.7 cm (by) (depth) 1.2 cm . 1.0 cm tunneling at 10 o'clock . peri wound same . .4/9/18 . (length) 3.0 cm (by) (width) 3.2 cm (by) (depth) 1.2 cm . (1.0 cm) tunneling at 10 o'clock . peri wound same . .4/16/18 . (length) 2.8 cm (by) (width) 3.2 cm (by) (depth) 1.4 cm . tunneling 1.0 cm at 10 to 11 o'clock . peri wound same . i. A physician's orders [REDACTED].Treatment . cleanse stage IV sacral wound with Dakin's solution, Pat dry, apply silver calcium alginate, cover with ABD (abdominal) Pad, secure with tape every other day (and) PRN (as needed) . j. A Care Plan with a revised date of 4/3/18 documented, .3/24/18 flexi-seal per manufacturer guidelines . monitor skin around tubing, monitor for s/s (signs / symptoms) of closed tubing, flush per guidelines . NSG (Nursing) staff to provide all ADL (activities of daily living) care to ensure daily needs are met . k. A Physician's Telephone order dated 4/12/18 documented, .T.O. (Telephone Order) . culture stage IV wound sacrum for any indications of infection . l. A Hospital Antimicrobial Susceptibility and Organism Identification Report dated 4/12/18 (with an admission and discharge date of [DATE]) documented, .Culture wound (and) Gram Stain . wound infection . Identity . Providencia stuartii and Staphylococcus aureus . m. A Physician's Telephone Order dated 4/16/18 documented, . T.O (Telephone Order) .[MEDICATION NAME] mg (milligrams) one tab BID (twice daily) (times) 10 days for wound infection per [DEVICE] (gastrostomy tube) . n. On 4/18/18 at 2:00 p.m., Resident #1 was lying in bed. Certified Nursing Assistant (CNA) #1 was called to the resident's room by the surveyor. CNA #1 was asked to check the resident for incontinence. CNA #1 removed the linens from over the resident. There was a dressing on the resident's coccyx wound that was soiled with brown and greenish stool that was liquid in some areas and dried in others. The incontinence brief, which was not fastened, appeared clean with the exception of some soiling caused by the soiled dressing, indicating a clean brief had been applied without changing the heavily soiled dressing. CNA #1 exited the resident's room in order to get supplies and assistance from other staff members to provide care for the resident. o. On 4/18/18 at 2:25 p.m., CNAs #1 and #2, and Licensed Practical Nurse (LPN) #1 entered the resident's room. The resident was lying in bed with the head of the bed elevated. The CNAs started to provide incontinent care for the resident and a tube coming from the resident's rectal area was visible. The soiled dressing on the resident's coccyx was dated 4/18/18. LPN #1 was asked what type of tube was coming from the rectal area and stated, Fecal tube. The rectal tube was attached to a collection bag, which was full to capacity with fecal material, and the rectal tubing was packed with solid feces, from the resident's buttocks to the collection bag opening. LPN #1 was asked if anyone had reported the soiled dressing earlier in the shift and stated, No. The staff provided incontinent and wound care for the resident. The staff exited the resident's room without changing the collection bag and checking the position of the rectal tube. p. On 4/18/18 at 3:15 p.m., CNA #1 was asked if the resident was soiled and if the rectal tube was leaking. She stated, I just got to work, and this is my first time in her room. She was asked, how long has the resident's rectal tube been leaking? She stated, About a week. q. On 4/18/18 CNA #1 and LPN #1 were asked who was responsible for emptying the resident's rectal bag, and how long had it

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F 0690 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) been leaking. They were also asked, should it leak, and has the leakage been reported to the doctor or the nurse. Their responses were as follows: 1.) At 2:25 p.m. CNA #1 stated the rectal tube had been leaking for about 1 week and that the bag should be emptied every 2 hours, as needed, and after every shift. CNA #1 was asked when the bag was last emptied and stated, I don't know; I didn't know I was supposed to empty the bag. CNA #1 was asked if she had been trained in how to care for the rectal tube. She stated, No. She was asked, should you report to the nurse when the resident is soiled and that the stool is not draining into the fecal bag? She stated, Yes, and they knew the stool wasn't going in the bag. 2.) At 3:00 p.m., LPN #1 stated the facility staff had already been aware that the stool was not flowing through the bag. r. On 4/19/18 at 1:10 p.m., LPN #1 was asked who was responsible for emptying the fecal bag and how often. She stated, Nurses and CNAs can empty the bag and it should be emptied every shift. She was also asked what the purpose was for the fecal tube. She stated, To help wound healing. s. On 4/19/18 at 1:30 p.m., the Director of Nursing (DON) was asked, who is responsible for emptying the fecal bag and how often. She stated, The nurses are responsible for changing the bag, not emptying it! That's why I bought so many collection bags. The CNAs should report to the nurse when the collection bag needs emptying (changing). The flex-seal is used to promote wound healing. t. On 4/19/18 at 3:00 p.m., LPN #1, #3 and CNA #1 were at the resident's bedside. They were asked what they were doing for the resident. CNA # 1 stated, She was like this when I came into her room, and I told the nurse. The resident was lying on her right side. There was a soiled draw sheet and pad under the resident that had brown, loose stool on them, and they were rolled under the resident. The inserted fecal tube had stool in it, and the bag contained 100 milliliters (ml) of loose stool. The stool was still oozing from the resident's rectal area, around the rectal tube, onto the resident's skin. The Stage IV pressure ulcer was visibly soiled with fecal material. LPN #1 had the bedside table set up with 4 by 4's, wound cleanser, white strip (calcium alginate), and ABD (abdominal) pads. No Dakin's solution was available in the room. LPN #1 was asked what she was using for the treatments. She stated, while providing the treatment, Clean with wound cleanser, put on calcium alginate, ABD pad, and tape. LPN #1 was asked to measure the wound. The position the resident was lying in prevented the wound from accessibility for correct measurements. LPN #4 tried to reposition the resident so the entire pressure ulcer could be measured. LPN #1 measured the pressure ulcer, which was partially mashed together by the resident's buttocks, and stated, 2.8 cm (l) (by) 3 cm (w). The staff was asked to position the resident's buttocks so the entire wound was visible. After doing so, LPN #1's measurements of the wound were 3.0 (l) (by) 3.7 (w) (by) 1.6 (d), with 11:00 and 12:00 o'clock tunneling. The Stage IV pressure ulcer had a dark red area to the center of the wound bed, and the remainder of the wound bed was pale red. The peri wound had several opened areas that were pink / red. The peri wound was pale, wet and boggy in an area measuring approximately 3.0 cm (length) by 3.7 cm (width) by 1.6 cm (depth) with 11:00 - 12:00 tunneling. There was an opened red area approximately 1 (by) 1 cm on the left leg, close to the bottom of the buttock. The LPN covered this opened 1 (by) 1 cm area with an ABD pad. She did not measure the area or provide treatment. The fecal bag tubing was kinked at the end closest to the collection bag and was not allowing feces to empty from the rectum into the bag. After the care was completed, the staff left the room without removing the kink from the tubing or evaluating whether the rectal tube was positioned correctly to minimize leakage. u. On 4/19/18 at 3:45 p.m., LPN #1 was asked if they were finished with the resident's care. She stated, Yes. She was asked if the resident had any new skin breakdown on her buttocks. She stated, No. She was asked, how often she had to change the feces soiled dressing on her shift and stated, Three to four times. She was asked how long the peri wound had been pale, boggy and with open areas, and how long the opened area on the left leg near the buttocks had been present. She stated, It's macerated. She was asked if the peri area was getting better or worse. She stated, Since the stool stays on her, it's gotten worse. She was asked if the doctor was notified of the deterioration in the coccyx wound since the fecal bag had been in place and stated, He knows. She was asked, where do you document the fecal tube output. She stated, We did at first, but what for? v. On 4/20/18, staff were asked multiple questions, including: Are you familiar with the resident's care? When did the buttocks become macerated? What was done to prevent further skin breakdown? How often is the flexi seal changed during the day? Was the leaking of the fecal tube reported to the doctor? Do you notify the nurse of the fecal soilage? Has the leaking fecal tube been examined? Should measurements be accurate and the entire wound be measured? Should you report changes in skin breakdown to the physician? Should the fecal tube output be measured? Should the care plan document the resident has a flex seal tube? Was the physician notified of skin irritation on the resident's upper middle thighs? What are the resident's current physician's orders [REDACTED].? Was the doctor notified of the changes in the coccyx? Who is responsible for emptying or changing the rectal tube collection bag? Who trained you on the flexi-seal? Their responses were as follows: 1.) At 1:35 p.m., CNA #3 stated, Yes, I am familiar with the resident's care. The pressure ulcer started to worsen about 2 weeks ago . We were told the purpose of the flex seal tube was to keep stool out of the pressure ulcer and we should be emptying and checking the fecal bag often. She is soiled about 3 or 4 times a day. The dressing has to be changed, and I report the soilage to the nurse. The fecal tube has been leaking about 1 week. I reported the leaking tube to the nurse. She said she would observe the tube. Later on in the day, it would leak again. The leakage wasn't coming from the tube, but from the rectal area. Nurses and aides empty the fecal bag as soon as it is halfway full. We empty the bag, and the nurse changes the bag . When asked about the Flexi-Seal training she had received, she stated, I was told to empty the fecal bag. 2.) At 2:00 p.m., the Treatment Nurse, (LPN #1), stated, Yes, I am aware of her plan of care. The wound on her coccyx was present when I started working about 2 months ago. It gets better, then worse, depending on how many stools she has. Sometimes the peri wound has opened areas in it, and sometimes it doesn't. We used to measure the open areas on the peri wound, but we stopped. I have measured the open areas on the peri wound once. I call and report drastic changes of the wound to the physician, like odors, and if it gets worse or better. I just called him on Monday (4/16/18) to give him an update that there were no changes in the wound. I use Dakin's solution to clean the wound, silver calcium alginate, and ABD dressing. The Flexi-seal is to keep stool out of the wound. I empty the bag prn (as needed). We don't have an order to change the bag, but I have changed it before. (Physician #1) ordered the Flexi-seal and I reported the leakage to the wound care doctor (Physician #2). I left a message with (Physician #1), but she hasn't got back with me. We inserted the tube in the facility. It's been leaking for a few weeks. I didn't document that the fecal tube was leaking, and I didn't document I called the physician. I didn't notify the physician (#2) of the measurement changes yesterday, because I didn't write them down yesterday. If you tell me the measurements, I will notify him. The opened area on the left upper leg has always been there. The Flexi-seal is to prevent stool from getting into the wound. If it doesn't work, we will try something else. I only document that the peri wound is denuded or macerated, not other changes in the peri wound . 3.) At 4:50 p.m., the Medical Director was contacted via telephone. She stated, I communicate closely with administration at the facility. I was aware of the stool coming from the Flexi-seal. I believe it was mentioned to me about two weeks ago. I believe the rectal tube was being repositioned. I was notified once of the stool expelling from the tube. I wasn't aware that stool was expelling from the tube daily. I was notified on Tuesday (4/17/18) of this week that the pressure ulcer was deteriorating. I received a call on Wednesday (4/18/18) that she (the resident) was placed on an antibiotic for a wound infection. 4.) At 5:10 p.m., the Director of Nursing stated, I'm not sure of all of her plan of care. She admitted in (MONTH) (YEAR) with the pressure ulcer on her coccyx, and I have not noticed a deterioration in the wound on her coccyx. The Flexi-seal tube was to prevent some of bowel movement from getting in the pressure ulcer. Only the nurses can change the fecal bag, not empty it. No one should be emptying the bag. Staff should report when the bag needs changing to the Treatment Nurse. I wasn't aware that the dressing was soiled with stool that frequently. I didn't report to the physician that fecal matter was coming from the tube. Yes, if we notice changes in the pressure ulcer, we should notify the physician. We were not recording the output of the fecal tube, because it wasn't required. Yes, the care plan and MDS should include the Flexi-seal. Yes, physician's orders [REDACTED]. I trained the Nurses that work on that end (where resident resides) about the Flexi-seal tubing. w. On 4/23/18 at 9:00 a.m., the Director of Nursing (DON) was asked if staff had received training for the Flexi-seal device. At 2:25 p.m. the DON provided an in-service dated 3/27/18 titled, Fecal Tube Irrigation. The in-service documented, .Nurses . Flexi-seal signal fecal management system . To irrigate the device . repeat the irrigation procedure as often as necessary to maintain proper functioning of the device . If repeated flushing with water does not return the flow of stool

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F 0690 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) through the catheter, the device should be inspected to ascertain that there is no external obstruction . If no source of obstruction of the device is detected, use of the device should be discontinued . Maintenance of device . Change the collection bag as needed. Discard used bag . Observe the device frequently for obstructions from kinks, solid fecal particles or external pressure . The in-service was signed by 12 Licensed Practical Nurses. LPN #1 was in attendance of the in-service. The in-service training did not contain documentation to indicate information related to the evaluation of the fecal tube's position to minimize leakage was included in the training. x. The Immediate Jeopardy was removed, and the scope and severity lowered to H on 4/20/18 at 6:00 p.m., when the facility implemented the following Plan of Removal: 1.) On 4/20/18 prior to 9:00 a.m., the rectal tube was removed for Resident #1 by the Director of Nursing, per the manufacturer's guidelines of leave in no more than 29 days. 2.) On 4/20/18 at 3:30 p.m., the MD (medical doctor) was notified of the change on condition of Resident #1's wound. 3.) On 4/20/18 at 3:30 p.m. the Treatment Nurse was in-serviced on proper wound measurements and documentation by the Director of Nursing. 4.) On 4/20/18 the Treatment Nurse completed a new body audit and recorded the findings for Resident #1. 5.) On 4/20/18 at 3:30 p.m., the Treatment Nurse was in-serviced on following physician's orders [REDACTED]. 6.) Starting 4/20/18 all nurses will be in-serviced on immediate notification of resident's change in condition to the resident's physician. 7.) Other Affected residents: 8.) All other residents with pressure wounds will have a body audit completed on 4/20/18 by the nursing staff, and notification to the MD of any negative findings. 9.) There are no other residents with rectal tubes. 10.) All residents' charts will be reviewed by the Administrator on 4/20/18 to ensure physicians have been notified of any change in conditions. 11.) Systemic Changes: 12.) All nursing staff will be in-serviced to report any change in condition to the physician promptly beginning 4/20/18 by the DON. 13.) QA Monitoring: 14.) The Administrator will monitor all resident's body audits weekly to ensure proper documentation of wounds for 8 weeks or until compliance is verified by the Office of Long Term Care. 15.) The Administrator will monitor all resident charts 2 times per week to ensure resident's change in condition is reported promptly to the physician for 8 weeks or until compliance is verified by the Office of Long Term Care. 16.) The DON will monitor treatments of residents with pressure wounds to verify that Physician order [REDACTED].
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 279) was substantiated, all or in part, with these findings. Based on observation, record review, and interview, the facility failed to ensure a [MEDICAL CONDITIONS] mask and the skin surrounding the [MEDICAL CONDITION] were maintained in clean condition and were free of excessive secretions to prevent potential infection or other complications for 1 (Resident #1) of 1 (Resident #1) case mix resident who had a [MEDICAL CONDITION] (trach). The failed practice had the potential to affect 1 resident who had a [MEDICAL CONDITION], according to a list provided by the Administrator on 4/23/18. The facility also failed to ensure oxygen was consistently administered at the physician-ordered flow rate to minimize the potential for respiratory complications, and respiratory masks were stored in a bag or covered container when not in use, to prevent potential cross-contamination that could result in respiratory infection for 1 (Resident #5) of 3 (Residents #1, #2 and #5) case mix residents who had physician orders [REDACTED]. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 3/30/18 documented the resident had severely impaired cognitive skills for daily decision-making per a Staff Assessment for Mental Status, was totally dependent on 2-plus people for bed mobility, required oxygen therapy and required suctioning. a. A physician's orders [REDACTED]. Oxygen . 5 [MEDICAL CONDITION] every shift with humidified air to keep secretions moist . DX (Diagnosis) . Shortness of Breath . b. The Care Plan with a revised date of 4/3/18 documented, .([MEDICAL CONDITION]) . Suction as needed . c. On 4/18/18 at 2:00 p.m., Resident #1 was lying in bed. Her [MEDICAL CONDITION] (trach) mask had light-tan, thick mucus hanging from the air holes on the mask and accumulated on the inner surface of the mask. There was also dried and wet mucus lines on the resident chest area below the [MEDICAL CONDITION]. Certified Nursing Assistant (CNA) #1 was informed at this time. 1.) At 2:25 p.m., CNA #1, CNA #2, and Licensed Practical Nurse (LPN) #1 entered the resident's room, followed by the surveyor. The resident was lying in bed, with the head of the bed elevated. A towel had been placed over the resident's chest area. Smears of tracheal secretions remained inside the resident'[MEDICAL CONDITION]. CNA #1, CNA #2, and LPN #1 were asked who had wiped the mucus from inside [MEDICAL CONDITION] and who placed the towel over the resident's chest. They all stated, I don't know. CNA #1 was asked to lift the white towel from the resident's chest. The dried mucus streaks remained on the resident's skin. Incontinent care was provided to the resident, then the staff left the resident's room without suctioning the trach, cleaning the remaining secretions from the inside of the resident'[MEDICAL CONDITION], or cleaning the dried secretions from the resident's chest area. 2.) At 3:15 p.m., CNA #1 entered the resident's room. CNA #1 was asked to remove the towel from the resident's chest area. The dried mucus streaks were still present on the resident's chest. CNA #1 retrieved a small towel, wet the towel with water, and rubbed the steaks of dried mucous, cleansing it from the resident's chest. The inside surfaces of [MEDICAL CONDITION] now had dried smears of mucus that had still not been cleaned. d. On 4/19/18 at 10:45 a.m., Resident #1 was lying in bed. There were thick white secretions inside the lower section of the resident'[MEDICAL CONDITION]. e. On 4/19/18 at 3:00 p.m., LPN #1, #3 and CNA #1 were at the resident's bedside. The resident was lying on her right side. There was thick mucus hanging from the resident'[MEDICAL CONDITION]. LPN #1 and #3 and CNA #1 provided wound care and indwelling urinary catheter care for the resident; however, no one suctions or cleaned [MEDICAL CONDITION]. After wound care was provided, the staff turned the resident onto her left side and secretions drained out of the resident'[MEDICAL CONDITION] and onto the floor. At 3:25 p.m., LPN #1 was asked, how often is the resident'[MEDICAL CONDITION]? She stated, In the morning. She was asked, what do you do when mucus is draining from [MEDICAL CONDITIONS]? She stated, Oh, I guess I could suction it. She was asked, what are the physician orders [REDACTED].? She stated, PRN (as needed). CNA #1 provided indwelling urinary catheter care. The resident'[MEDICAL CONDITION] not suctioned or cleaned. The resident was repositioned in the bed. The staff washed their hands, removed the soiled items, and exited the resident's room without suctioning the resident's trach. The resident was breathing normally, without exertion, and appeared in no distress. LPN #1 was asked what was used to clean [MEDICAL CONDITION]. LPN #1 stated, A paper towel. f. On 4/20/18, staff were asked: Are you familiar with the resident's care? How often is the resident'[MEDICAL CONDITION] cleaned? How often should the resident'[MEDICAL CONDITION] suctioned? Does the resident have copious secretions? Should the resident's skin remain free of wet and dried mucus? Their responses were as follows: 1.) At 1:35 p.m., CNA #3 stated, Yes, I am familiar with the resident's care. When we see [MEDICAL CONDITION] dirty, we report it the nurse. The secretions are thick. We keep a towel on her chest because she has lots of mucus draining. 2.) At 2:00 p.m., the Treatment Nurse (LPN #1) stated, Yes, I am aware of her plan of care. I suction [MEDICAL CONDITION] and prn. She has lots of mucus secretions, and I check her vital signs and check for respiratory distress, and then I would suction the trach. g. On 4/20/18 at 5:10 p.m., the Director of Nursing was asked about the resident's tracheal secretions and stated, .I'm aware she has a lot of mucus drainage from the trach. [MEDICAL CONDITION] should be cleaned daily and changed once a week. The mask should not be wiped out with paper towels, but should be cleaned with normal saline. She should be suctioned as needed. h. The facility's policy and procedure [MEDICAL CONDITION], provided by the Administrator on 4/20/18, did not include

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045275	A. BUILDING _____ B. WING _____	04/23/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACE POINT, LLC	1700 EAST SHORT HILLSBORO EL DORADO, AR 71730

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) tracheal suctioning or cleaning of [MEDICAL CONDITION]. 2. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/16/18 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status, required extensive assistance of 1 person for bed mobility and transfer, and required oxygen therapy. a. The Plan of Care with a reviewed date of 1/22/18 documented, .Resident has new [DIAGNOSES REDACTED]. has been on the vent (ventilator) while in hospital and remains at risk for SOB (shortness of breath) . Updrafts per MD (Medical Doctor) orders . [MEDICAL CONDITION] every HS (hours of sleep) . b. A physician's orders [REDACTED].Oxygen . 2 liters (via) nasal cannula every shift to maintain O2 (oxygen) sats (saturation) 90 (and) above . Diagnosis . SOB (Shortness of breath) . [MEDICAL CONDITION] (bi-level positive airway pressure) 20/10, FI02 (fraction of inspired oxygen) 30% inhalation hs (hour of sleep) . may use prn (as needed) for SOB (shortness of breath) (and) lethargy at nursing home . Use when resident is taking a nap (and) anytime resident is sleeping . A physician's orders [REDACTED].[MEDICATION NAME] ([MEDICATION NAME] - [MEDICATION NAME]) Inhalation solution 3 ml (milliliters) inhalation every 4 hours prn (as needed) . ([MEDICATION NAME] - [MEDICATION NAME]) 0.5 - 2.5 mg (milligrams) (per) 3 ml . c. On 4/18/18 at 1:55 p.m., the resident was lying in bed. The resident's [MEDICAL CONDITION] mask and updraft mask were uncovered and lying on the resident's bedside table. At 3:15 p.m., the [MEDICAL CONDITION] mask and updraft mask remained on the bedside table, uncovered. d. On 4/19/18 at 9:25 a.m., the resident was in a recliner in her room, asleep. The resident's oxygen was on and the flow rate was set at 3 liters per minute (LPM) instead of 2 LPM as ordered by the physician. The resident's [MEDICAL CONDITION] mask was lying on the top of the [MEDICAL CONDITION] machine, uncovered, and the updraft mask was stored in the top of the updraft machine, uncovered. At 12:18 p.m., the resident's oxygen was on and the flow rate was set at 3 liters per minute per nasal cannula. The resident's [MEDICAL CONDITION] mask and updraft mask were still uncovered. At 2:55 p.m., the resident was in bed, lying on her back, asleep. The resident's oxygen was on with the oxygen flow rate set at 2 and ¾ liters per minute per nasal cannula. At 3:00 p.m., Licensed Practical Nurse (LPN) #2 was asked what the resident's oxygen flow rate should be. She checked the physician orders [REDACTED]. The Surveyor went into the resident's room with the nurse. Upon entering the room, LPN #2 stated, It's not on 2 liters, is it? I can tell that from here. It's on about 2 and ¾ liters per minute. The nurse adjusted the oxygen flow rate to 2 liters per minute. e. On 4/19/18 at 1:30 p.m., LPN #1 was asked what was used to clean [MEDICAL CONDITION]. LPN #1 stated, A paper towel. f. On 4/20/18 at 4:15 p.m., the resident was asked if she used her [MEDICAL CONDITION] at night. She's stated, Yes, I wear it. She was asked if she wore her [MEDICAL CONDITION] mask last night. The resident stated, Yes, I wore it last night. LPN #2 was asked if the resident had been wearing her [MEDICAL CONDITION] at night. She looked on the Medication Administration Record [REDACTED].