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	165515	A. BUILDING _____ B. WING _____	C 12/29/2017

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SUNNYCREST NURSING CENTER	401 CRISMAN STREET DYSART, IA 52224

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F 000	INITIAL COMMENTS VKK 1/17/18 Correction date 1/15/18 12/29/17-641 & 686 The following deficiencies relate to the investigation of complaint #72824. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000	This plan of Correction (POC) constitutes Sunnycrest Nursing Center's requirement to submit a credible allegation of compliance. This POC does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness set forth by the agency. The submission of the POC should in no way be considered or construed as agreement with the allegations or noncompliance or admission by the facility. We are providing this POC to comply with Federal participation requirements	
F 641 SS=G	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews and observations, the facility failed to perform assessments of 5 residents identified with a non-pressure skin impairment (Residents #2, #5, #7, #14, and #18). The facility census was 39 residents. Findings include: 1. Resident #14 had a Minimum Data Set (MDS) assessment with a reference date of 12/1/17. The MDS identified Resident #14 had diagnoses which included diabetes, heart failure, depression and chronic lung disease. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 4. A score of 4 identified the resident with severe cognitive impairments. The MDS indicated the resident required limited assistance of 1 staff member for bed mobility, transfers, walking and dressing. The MDS indicated the resident had a risk for the development of pressure sores but at the time of the assessment did not have pressure sores or	F 641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Madson — TITLE: Administrator — (X6) DATE: 1-16-18

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.

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F 641	Continued From page 1 any type of skin impairment. The resident utilized a pressure relieving cushion in the chair and on the bed. According to the Care Plan updated on 9/4/17, the resident had the potential for impairment of skin integrity but failed to identify the resident had an open area to the left great toe. Review of the December 2017 Treatment Record identified an order for staff to apply Triple Antibiotic Ointment to the left great toe and cover with a gauze dressing every day until healed. The staff failed to complete the daily dressing changes as ordered on 12/5-12/7/17. Review of the Wound/Skin Healing Record, the resident had a diabetic ulcer which staff noted on 8/16/17 and completed a skin assessment sheet. Review of the record revealed the staff failed to assess the diabetic ulcer from 11/16-12/16/17. The record revealed the wound to the left great toe measured 0.1 centimeter by 0.1 centimeter on 11/16/17 and the assessment on 12/16/17 measure .5 by .25 centimeters. According to the Weekly Pressure Ulcer Progress Report Policy and Procedure dated 5/23/14, the policy directs staff to provide weekly assessments for all pressure/stasis ulcers to help prevent infections and other complications of pressure/stasis ulcers. The policy directed staff to assess weekly, document in the nurse's notes so the area will be monitored weekly. The policy identified the Charge Nurse would be responsible for the ulcer weekly assessments and documentation. 2. Resident #7 had a MDS with a reference date	F 641	F 641 Resident #2, 5, 7, 14, and 18 will have weekly assessments completed on non-pressure skin impairments as warranted. Residents will have weekly assessments completed on non-pressure skin impairments as warranted. Nursing staff were in-serviced on 12-17-17 and 12-19-17 regarding the completion of weekly skin assessments on non-pressure skin impairments. DON and/or designee will complete routine audits regarding weekly skin assessments on non-pressure skim impairments. The findings of these audits will be reported to the facilities quarterly QAPI committee. Compliance 12-29-17	12-29-17

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F 641	Continued From page 2	F 641		

of 10/17/17. The MDS indicated the resident's diagnoses included muscle weakness, obesity, ventral hernia and a fistula of intestine. The resident could independently move about in bed, required supervision of 1 person for transfers and moved about independently in the facility. The resident had a BIMS score of 15. A score of 15 identified the resident had no cognitive impairments. The MDS revealed the resident did not have a risk for pressure sores but did have a surgical wound.

Review of the Care Plan with a reference date of 8/11/17, identified the resident had a skin issue related to a post-surgical procedure and required daily dressing changes. The Care Plan indicated the resident had a referral to a local wound clinic on 12/15/17, to change wound dressing per orders, monitor for signs of infection and to be in contact isolation.

According to the physician's order dated 12/18/17, the physician ordered the resident's abdominal wound dressing changed twice daily and as needed due to a wound infection. The orders directed staff to pack left abdominal wound with nu-gauze soaked in normal saline twice daily and apply 0.0125% Dakin's solution soaked gauze to abdominal dehisced surgical wound twice daily and cover with pads.

According to the Treatment Administration Record dated December 2017, the staff failed to completed dressing changes as ordered on 12/5 am and pm shifts, 12/12 am shift, 12/14 pm shift 12/19 pm shift and 12/22 am shift.

Review of the non-pressure skin condition report revealed the staff measured the resident's wound

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F 641	Continued From page 3	F 641		

weekly until 11/16/17. The condition report identified the facility staff failed to measure the resident's wound from 11/16/17 until 12/16/17. The resident is noted to have a surgical wound on the abdominal pannus which measured 13 centimeters (cm) by cm with a 4.5 centimeter by 1 cm open in the midline of the wound. The wound measurements on 11/16/17 were 10 centimeters by 0.5 centimeters with serosanguinous drainage which cultured pseudomonas. The physician started the resident on antibiotic therapy on 11/18/17.

According to the Treatment Administration Record dated December 2017, the resident had a change in wound dressing orders on 12/22/17 which directed the staff to gently scrub the abdominal wound with soap and water, rinse, pat dry and apply Mepilex border to cover wound one time every three days. The record indicated the dressing should be changed on 12/25 and 12/28/17. The record revealed the staff indicated they changed the dressing on 12/25/17 but the resident indicated the staff did not change the dressing that he refused and wanted it done on 12/26/17 after his shower.

During an interview with Resident #7 on 12/26/17 at 9:30 a.m., the resident stated the staff nurse did not change his wound dressing yesterday as he wanted it changed today after his shower.

3. Resident #2 had a MDS with a reference date of 11/2/17. The MDS identified the resident had diagnoses which included right hemiplegia (weakness or inability to move a leg and arm), anxiety, depression, muscle weakness and colon cancer. The resident had a BIMS score of 8 which indicate moderate cognitive ability without

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F 641	Continued From page 4	F 641		

long and short term memory problems. The resident required extensive assistance of 1 person with bed mobility, transfers, dressing and limited assistance with walking. The resident did not have skin fissures but the staff indicted she was at risk for developing pressure sores.

Review of the Care Plan updated on 11/6/17 informed staff the resident had a risk for skin breakdown and directed staff to turn/reposition every 2 hours as resident allows and complete treatments and dressings as ordered.

Review of the Progress Notes dated 11/16/17 the staff found Resident #2 on the floor on her right side. The resident found to have a 7 centimeter by 5 centimeter dark purple bruise area to right arm. The progress notes do not reference the bruised area or skin condition until 12/16/17 at 4:10 p.m. when the Director of Nurses applied a dressing to the resident's right arm.

Observation on 12/15/17 at 11:00 a.m., the resident still in bed. Upon examination per the DON (Director of Nursing) the resident had a skin tear that measured 2.5 cm by 1 cm covered by a dressing. The dressing was removed and dark red bloody drainage noted when the dressing removed.

During an interview with the DON on 12/15/17 at 11:00 a.m., the staff failed to make out a skin sheet for the skin tear and she had no knowledge of the area.

Review of a Non-pressure Skin Condition Report dated 11/16/17 revealed the resident had a dark purple bruise to their right arm which measured 7 cm by 5 cm but indicated only a bruise.

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F 641	Continued From page 5 Review of a Non-pressure Skin Condition Report dated 12/16/17, indicated the resident noted to have a 2.5 cm by 1 cm skin tear with scabbing. Review of the December Physician's Orders report failed to contain an order for treatment to the skin tear on the resident's right arm. 4. According to the MDS dated 12/14/17, Resident #18 had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and osteoarthritis. The resident had a BIMS score of 15 indicating no cognitive impairments. The resident required extensive assistance of one person with bed mobility, transfers, walking and dressing. The MDS indicated the resident had a risk for the development of pressure sores but did not have skin issues. Review of the Care Plan, revised on 9/19/17 indicated the resident had an increased risk with potential for pressures ulcers due to immobility and level of assistance. The intervention dated 12/15/17 identified the resident had a skin tear to his outer left arm and directed the staff to cover the skin tear. Review of the Progress Notes dated 11/29/17 at 1:30 p.m. the resident experienced a fall which resulted in a skin tear on the upper arm which measured 1 cm by 1 cm with bleeding noted. The staff applied a bandage to the area. Review of the Non-pressure Skin Condition Report dated 11/29/17 identified the resident obtained a skin tear on the upper left arm. Review of the report identified no further assessments of the skin tear.	F 641		

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F 641	Continued From page 6 Review of a Non-pressure Skin Condition Report dated 12/15/17, completed by the DON, indicated an assessment of the upper outer left arm skin tear. The reported noted the skin tear measured 1.5 cm by 1 cm with a scabbed area. Review of the November and December Treatment Administration Records failed to reveal the resident sustained a skin tear and failed to indicate a treatment. During an interview with the DON on 12/15/17 at 3:00 p.m., there are no further assessments of the resident's skin tear since 11/29/17 when the skin tear occurred. 5. Resident #5 had a MDS with a reference date of 9/28/17. According to the MDS dated 9/28/17 Resident #5 had diagnoses which included heart failure, Dementia, heart disease. The resident could not participate in the Brief Mental Status interview which indicated severe cognitive ability. The resident required limited assistance of one person for bed mobility, transfers, walking and dressing. The MDS revealed the resident not at risk for the development of pressure sores and did not have skin issues. Review of the Care Plan dated 12/18/17 revealed the resident had an actual impaired skin integrity related to a surgical procedure. The Care Plan revealed the resident's physician "froze" an area near the tip of the resident's nose. The plan included and directed staff to assess for risk factors related to skin breakdown and apply topical treatment as ordered. Review of the December Treatment	F 641		

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F 641	Continued From page 7 Administration Record directed staff to apply triple antibiotic ointment to the scratch at tip of nose twice daily until redness healed, initiated on 11/7/17. Review of the Progress Notes dated 10/201/7, the resident noted with increased redness around the outer edges of scab on top of nose. Review of a physician's clarification order dated 11/7/17 directed staff to apply triple antibiotic ointment on the tip of the nose twice daily until healed. Review of the Physician Notification Report dated 11/7/17, the staff notified the physician the resident's nose had swelling and recurring bleeding related to the resident's continuous scratching of the area. The physician ordered triple antibiotic ointment to be applied until healed. The Non-pressure Skin Condition Report dated 10/8/17 revealed the resident had a 3 cm open area of skin near the tip of nose. The staff assessed the condition of the skin to the resident's nose last on 11/16/17 and did not assess again until 12/16/17. The Non-pressure Skin Condition Report dated 12/16/17 and completed by the DON, identified an assessment measurements of .25 cm by .2 cm. The DON noted there appears to be two open areas on the resident's nose, the other area too small to measure.	F 641		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		

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F 686	Continued From page 8 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews, the facility failed to provide appropriate wound care services for 6 of 6 residents with pressure sores placing residents as immediate jeopardy to their health and safety. (Residents #4, #6, #8, #9, #11, and #13) The facility failed to provide timely wound assessments for 6 of 6 residents, the facility failed to provide treatments as prescribed for Residents #4, #6, #8, failed to update and follow the planned Care Plans for Residents # 6, #8, #11, #13, failed to notify the primary care physician for Residents #4, #11 and failed to identify a pressure sore for Resident #4, #11. The facility census was 39 residents. Findings include: The Minimum Data Set (MDS) assessment described the stages of pressure sores as the following: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not	F 686	F686 Resident's #4, 6, 8, 9, 11, and 13 will have wound assessments completed in a timely manner. Resident's #4, 6, and 8 will have treatments completed as prescribed by the physician. Resident's #6, 8, 11, and 13's care plans have been updated. Resident #4 and #11 will have primary care physician notified of pressure sores. Resident #4, and #11 will have pressures sores identified. Residents will have wound assessments completed on a weekly basis, have treatments completed as prescribed by the physician, have care plans updated as warranted, have physician notified of pressure sore, and will have pressure sores identified. Nursing staff in-serviced 12-17-17 and 12-29-17 regarding weekly assessments, treatments completed as ordered, care plans being updated, physician's being notified of pressure sores, and pressure sores being identified.	12-29-17

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F 686	Continued From page 9 have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. 1. Resident #8 had an admission MDS with a reference date of 12/11/17. The MDS identified the resident had diagnosis which included a fractured fifth vertebrae (neck), depression, and elevated blood pressure. The MDS indicated the resident required extensive assistance of one staff member for bed mobility, transfers, dressing and independently moved about the facility in his wheelchair. The MDS indicated the resident had 1 Stage II pressure sore on admission and at risk for the development of pressure ulcers. The resident had a Brief Interview for Mental Status (BIMS) score of 14. A score of 14 identified the resident had no cognitive impairments with long and short term memory. Review of the Care Plan dated 11/30/17, identified Resident #8 with impaired skin integrity related to decreased mobility. The staff updated the Care Plan on 12/18/17 and identified the staff	F 686	DON and/or designee will complete routine audits regarding, weekly wound assessment, treatments being completed as ordered, care plans being updated, physician's being notified, and pressure sores being identified. The findings of these audits will be reported to the facilities QAPI committee on a quarterly basis. Compliance Date: 12-29-17	

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the resident had a right heel blister. The interventions directed the staff to place Moon Boots (pressure relieving boots-suspends heels) to both feet at all times. The Care Plan interventions, prior to the development of the pressure ulcer, directed the staff to assist with repositioning as needed, cushion to the wheelchair, pressure reducing mattress on the bed and monitor for signs and symptoms of skin impairment with routine cares, showers, and as needed and apply topical treatment and dressing as ordered.

Review of the physician Admit/Re-Admit orders dated 11/28/17, indicated the physician directed staff to place a Duoderm dressing to the resident's right heel ulcer and to change daily, to apply ace wraps to both lower legs; on in morning off in evening and to wear Moon Boots on both feet at all times while in bed.

A podiatrist orders dated 12/1/17, directed the staff to continue to off-load right heel and to have the resident wear off-loading boots when in a wheelchair as well as in bed. The facility staff noted the physician order on 12/2/17.

Review of the December 2017 Treatment Administration Record (TAR) indicated the resident had an order to place Duoderm to the right heel blister daily, ace wraps to both lower legs on in am and off in pm and Moon Boots on both feet at all times while in bed, initiated on 11/28/17. The TAR revealed a second order initiated on 12/2/17 directed to staff to apply Moon Boots to the residents right foot while in wheelchair and when in bed, every shift for a right heel blister. Review of the December Treatment Record revealed the staff failed to sign off as

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completed: Duoderm on 12/5, 12/18 and 12/25/17, Ace wraps on 12/5 and 12/25/17 and off-loading boots on 12/5 and 12/25/17.

On 12/15/17 at 2:50 p.m., observation identified Resident #8 sitting in the dining room in a wheelchair without ace wraps on legs and without off-loading boots on feet. The Director of Nurses (DON) moved the resident to the shower room to observe the right foot skin condition. The DON removed the resident's gripper socks and the right foot noted to be edematous (swollen) and noted the resident had a dressing to right heel (undated). The DON removed the dressing and noted a black heel ulcer (unstageable to the right lateral heel which measured 4.5 centimeters (cm) by 3 cm. The resident commented several times how swollen both of his feet were at this time.

On 12/19/17 at 8:45 a.m., the DON was interviewed and stated the resident did not have a skin assessment sheet for the heel ulcer and staff never made one upon admission. The DON acknowledged the resident admitted to the facility with the ulcer on 11/28/17 and stated the ulcer had not been measured since admission.

Observations on 12/15 at 11:10 a.m. and 2:50 p.m., 12/19/17 at 12/35 p.m. and 3:00 p.m., 12/20/17 at 9:30 a.m., 12/26 at 9:20 a.m. and 12/28/17 at 5:45 a.m. failed to show the staff placed the resident's ace wraps to both lower legs and failed to put on the off-loading boots (moon boots) to the resident's feet. During an interview with the resident on 12/28 at 5:45 a.m., the resident stated he didn't have them on all night; no one came to put them on last evening.

During an interview with Resident #8 on 12/19/17

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at 3:10 p.m., the resident stated the staff stopped changing his dressing to heel ulcer a while ago but all of a sudden at the end of last week they began to do the heel dressing changes again every day. The resident stated his feet seem to be quite swollen and hasn't had his ace wraps on.

During an interview with Resident #8 on 12/26/17 at 9:20 a.m. the resident stated they did not complete his daily dressing change yesterday to the right heel. Observation during the interview noted the resident did not have on his ace wraps as ordered or his off-loading boot to feet. Observation at this time revealed the Duoderm to the resident's right heel ulcer had a date of 12/24/17 written on the dressing.

Review of the December 2017 Treatment Record revealed the staff failed to sign off the pressure sore treatment to the resident's right heel on 12/25/17, during the day shift and failed to apply Ace wraps as ordered on 12/25/17.

Review of the Wound/Skin Healing Record identified the resident had a pressure sore to the right heel on admission. Review of a Wound/Skin Healing Record dated 11/28/17 identified the resident had a blister on his right great toe which measured 4.0 cm by 3.8 cm, blister intact. The record indicated the first right heel measurement completed on 12/16/17, the staff identified the wound as a Stage II pressure ulcer which measured 3 centimeter by 2.5 centimeters.

Review of the Admission Assessment dated 11/28/17 indicated the resident had a blister to the left lateral heel and would measure this evening.

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The policy and procedures titled Weekly Pressure Ulcer Progress Report Policy and Procedure dated 5/23/14, directed the staff to provide weekly assessment for all pressure/stasis ulcers to help prevent infections and other complications of pressure/stasis ulcers. The policy directed staff to assess weekly, document in the Nurse's Notes so the area will be monitored weekly. The policy indicated the Charge Nurse would be responsible for the ulcer weekly assessments and documentation.

2. Resident #4 had a MDS with a reference date of 9/21/17. The MDS identified the resident had diagnoses which included diabetes mellitus and multiple sclerosis. The resident required extensive assistance of 2 staff members for bed mobility, transfers and dressing. The MDS identified the resident at risk for the development of pressure ulcers and currently had 1 Stage III pressure sore. The MDS indicated the resident had a BIMS score of 14 and had no cognitive impairment.

According to the Care Plan dated 9/28/17, the resident had the potential for impaired skin due to a history of breakdown and immobility. The Care Plan directed staff to provide a low air loss bed, consult the wound clinic per Dr. orders, apply moon boots while in bed, reposition every two hours and an air cushion in the chair. The Care Plan failed to indicate the resident had a pressure sore and failed to provide direction to staff for the Stage III pressure sore.

Review of the Wound/Skin Healing Record on 12/14/17 revealed staff last assessed Resident #4's pressure sore on 11/16/17. The staff measured the coccyx wound as 0.2 cm by 0.2

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cm.

Review of the Wound/Skin Healing Record dated 12/16/17 indicated the staff noted two slit type wounds, wound #1 measured 2 cm in length and wound #2 measured 0.25 cm in length.
Review of the Wound Healing Center Orders/Discharge Instructions dated 12/12/17 indicated the wound to the coccyx measured 4.5 centimeters by 1.5 cm by 0.2 cm. The orders directed the staff to cleanse the wound with warm water to clean soiling but do not wash the entire product off of the skin. The primary dressing of stoma paste was ordered to be applied twice daily and as needed and then apply a secondary dressing of order zinc oxide 40% applied twice daily and as needed.
Review of the December Treatment Record obtained on 12/20/17 revealed the staff initiated a new skin treatment order on 12/15/17 which included the following: complete wound care twice daily, cleanse coccyx with warm water, and apply zinc oxide 40%. Do not remove zinc oxide with cares unless soiled. Review of the December TAR revealed the staff did not initiate the order for 3 days after the physician ordered the dressing and incorrectly noted the order. The facility failed to direct staff to apply Stoma powder to the wound followed with zinc oxide.

Review of the Wound Clinic Physician's orders dated 12/13/17 directed the staff to cleanse the coccyx wound with warm water to clean soiling, do not wash off all the product, apply stoma powder as the primary dressing and secondary dressing of zinc oxide 40% twice daily and as needed.

During an interview with the Wound Clinic on

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F 686	Continued From page 15 12/29/17 at 8:42 a.m. confirmed the orders were noted incorrectly, the stoma powder and the zinc oxide needed to be applied to the wound to form a crust over the pressure sore. The area observed on 12/13/17 is a new pressure area and the wound appears to be either from tape to the area or the resident laid on something which created a new pressure area. The clinic nurse stated the delay in initiating the correct orders will delay wound healing. Review of the December Treatment Record indicated the resident had a skin treatment order initiated on 10/5/17 of the following: cut Prisma into very thin strips and pack gently every 72 hours for coccyx wound. Do not cleanse and cover with 4 x 4 border. The record indicated the staff failed to sign off the treatments on 12/6 and 12/12/17, review of the order revealed staff discontinued it on 12/14/17. On 12/19/17 at 1:00 p.m. Resident #4's primary care Nurse Practitioner, was interviewed and stated she was not aware the resident continued to have an open area to the coccyx. The Nurse Practitioner stated even though the resident goes to the wound clinic, she still needs to be notified of the skin issues so she could monitor the resident. She stated the last communication regarding the skin issue was sometime in November. The Nurse Practitioner stated the resident becomes very upset and tearful when she has an open area because it limits her time she can be out of bed. Observation on 12/20/17 at 2:05 p.m. Staff A -Agency RN entered the resident's room for wound care. Staff assisted the resident to roll to her left side, with a soapy washcloth. Staff A	F 686		

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cleansed the resident's coccyx area and dried area. Staff A reapplied to resident's coccyx area Zinc 40% white cream, covering the resident's bottom area. Staff A failed to apply stoma powder to the area per order prior to applying the Zinc. Observation of the Zinc 40% tube, the tube had a yellow tag which revealed the staff opened the tub of cream on 12/15/17.

On 12/20/17 at 3:20 p.m., the DON was interviewed and questioned about the treatment order of stoma powder and Zinc 40%. The DON stated she thought the stoma powder is to be used with the resident's colostomy and the Zinc cream used on the wound but stated she will call the Wound Clinic to verify the order.

The TAR (Treatment Administration Record), obtained on 12/28/17, the failed to show the correct wound treatment order. The current order on the TAR initiated on 12/15/17 continue to direct staff to cleanse the coccyx with warm water and to apply zinc oxide 40% and not to remove the zinc oxide with cares unless soiled.

On 12/15/17 at 8:00 a.m., the resident stated she did not always get turned every 2 hours during the night. The resident recently had a wound clinic appointment on 12/13/17 and received new orders for her coccyx wound. The resident stated the staff are not putting on stoma powder as ordered and they don't have the zinc oxide cream yet as the wound specialist ordered.

On 12/14/17 at 10:48 p.m., Staff D (licensed practical nurse) was interviewed and stated she thought Resident #4 as the only resident in the building with a pressure sore. Staff D stated she has worked full time night shift at the facility for

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F 686	Continued From page 17 the past 7 years. 3. Resident #11 had a MDS with a reference date of 10/12/17. The MDS identified the resident had diagnoses which included Alzheimer's disease, anxiety and diabetes. The resident had a BIMS score of 7 which indicated severe cognitive ability with short and long term memory problems. The resident required limited assistance of 1 staff for transfers, ambulation and ate independently. The MDS revealed the resident did not have skin breakdown and not at risk for developing pressure ulcers. Review of the Care Plan dated 12/18/17 indicated Resident #11 had actual impaired skin integrity. The Care Plan revealed the resident had a skin tear but failed to indicate the resident had a pressure sore to the coccyx area which staff identified on 11/19/17. During an interview with Staff B-MDS RN on 12/20/17 at 3:40 p.m. regarding the lack of wound care planning, Staff B stated she has been the only RN in the building since the last DON resigned in October and is unable to update the Care Plans. During an interview with the DON on 12/15/17 at 11:55 a.m., the DON stated the nurse who measured the wounds and completed assessments resigned, doesn't know the date and didn't know who did the wound assessments after she left. The DON stated she began her employment at the facility on December 11, 2017. Review of two Non-pressure skin condition reports obtained on 12/14/17 at 9:00 p.m. revealed the resident had two skin issues: a skin	F 686		

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tear first observed on 11/28/17 and an open area on the coccyx area first observed on 11/19/17. The coccyx wound measure .8 cm circular and not staged and the skin tear to the left arm measured 1 cm by 0.5 cm.
During an interview with Staff B-MDS coordinator on 12/14/17 at 9:00 p.m. revealed there are only 2 non-pressure skin condition reports for the resident at this time. The skin condition sheets for the left arm skin tear and the coccyx wound revealed staff failed to assess the skin areas after they were both identified.

Review of two Non-pressure skin condition reports obtained on 12/15/17 revealed the resident had two skin issues: a skin tear on the right lateral forearm which measured 1.5 cm by 1.5 cm and two Stage II pressure ulcers to the left gluteal cleft. Wound #1 measured 0.5 by 0.5 cm. and wound #2 measured .25 by .25 cm.

According to the Progress Notes dated 11/1/9/17 revealed a facility nurse identified an open area to the resident's left buttock with measured 0.8 cm in diameter.

Review of the December 2017 physician's order sheets failed to contain treatment orders for the resident's skin tear and pressure sores.
Observation of the coccyx wound with the DON on 12/15/17, the DON stated the resident had two open areas which measured .25 cm by. 25 cm and .5 cm x .5 cm, both areas did not have a dressing to the area. The DON assessed the resident's left arm and found a skin tear to the arm which measured 1.75 cm by 1.5 cm.

Observations of the coccyx wound care with the DON on 12/21/17 at 9:40 a.m., the DON

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measured the coccyx pressure area noting it measured .5 cm by .6 cm. The DON stated the new order for Desitin skin ointment had not been delivered from the pharmacy and they will apply Calm [Calmoseptine] ointment at this time.

During an interview with Resident #11's primary care Nurse Practitioner on 12/19/17 at 1:00 p.m., the Practitioner stated they were not aware the resident had a skin tear or pressure ulcer and the facility failed to notify her.

Review of the Pressure Ulcers list obtained on 12/14/17 at 10:27 p.m. failed to identify the resident had a pressure sore.

4. Resident #13 had a MDS with a reference date of 12/14/17. The MDS identified the resident had diagnoses which included diabetes mellitus, dementia, and psychotic disorder. The resident had a BIMS score of 13 which indicated no cognitive impairment ability. Resident #13 required extensive assistance of 1 staff person for bed mobility, transfers, walking and dressing. The resident had a risk for developing pressure sores and had one Stage II pressure ulcer.

Review of the Care Plan, updated on 9/21/17, indicated the staff identified the resident at increased risk for skin breakdown and directed staff to assess/record/monitor wound healing weekly and to report improvements and declines to the doctor. The Care Plan directed staff to apply Aloe Vesta to the coccyx with cares as resident allows and to turn and reposition every two hours throughout the shift.

Review of the Wound/Skin Healing Record obtained on 12/14/17 at 9:00 p.m. indicated the

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resident had an onset on 10/22/17 of a Stage 1-upper left buttock pressure sore which measured 1 cm by 3 cm on 11/10/17. The assessment completed on 11/10/17 was the last assessment completed until 12/16/17 when the DON assessed the wound.

Review of the December 2017 Treatment Administration Record directed the staff to apply Camosyn to the area on the coccyx twice daily and as needed. The staff failed to apply the cream on 12/5, 12/7 and 12/19/17.

Observations on 12/21/17 at 11:45 a.m. with the DON, identified measurements of the buttock pressure sore on this day were 1.3 cm by 1.5 cm.

Review of the Pressure Ulcers list obtained on 12/14/17 at 10:27 p.m. failed to identify the resident had a pressure sore.

6. According to the Admission Record dated 11/8/17, Resident #9 had diagnoses which included cellulitis (skin inflammation) of a limb, urinary dysfunctions, cardiac disease and kidney disease.

According to the MDS with an assessment date of 6/30/17, the resident had a BIMS score of 13 which indicate no cognitive problems. The resident required limited assistance of 1 staff person for bed mobility, transfers and walking.

Review of the Care Plan dated 11/9/17 and revised on 12/15/17 revealed the resident had one pressure ulcer on the left heel and left great toe. The Care Plan directed staff to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound

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F 686	Continued From page 21 weekly for healing and complications. The Care Plan directed staff to monitor wound dressing every shift to ensure it is intact and adhering and to wear a Prafo boot while in bed. Review of the Wound/Skin Healing Record obtained on 12/14/17 at 9:00 p.m., identified the following areas: a. Pressure ulcer on right great toe with measurements 1.5 cm by 1.4 cm. b. Pressure ulcer to the left heel measured 1.8 cm by 1.0 cm. The Record revealed the staff failed to assess the pressure sores from 11/8/17 until 12/16/17. Review of the Wound/Skin Healing Record indicated the resident had 2 pressure ulcers with measurements on 12/16/17 of the following: a. Pressure ulcer to the right great toe measured 2.25 cm by 1.5 cm. b. Pressure ulcer to the left heel measured 1.75 cm by .75 cm. Review of the Order Review Report dated December 2017, the physician directed staff: To cleanse the ulcer to the left great toe, paint with breadline, wrap with rolled gauze every other day and as needed. Review of the November 2017 Treatment Administration Record directed staff to do the following wound care: cleanse ulcer to left great toe, paint with betadine, wrap with rolled gauze every shift for ulcer, apply foam dressing pad to left ankle and left heel wound topically one time per day related to cellulitis. Review of the Treatment Administration Record revealed the staff failed to complete treatment to	F 686		

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F 686	Continued From page 22 the left great toe on 11/20/17. Review of the December 2017 Treatment Administration Record revealed the facility staff failed to complete the dressing changes to the resident's left great toe on 12/5 and 12/7/17 and 12/20/17. Observation on 12/26/17 at 2:30 p.m. revealed the following wound measurements and treatments: a. Left great toe measures .4 cm by 1 cm, area cleansed with wound cleansers and painted with Betadine. b. Left heel pressure ulcer measured .8 cm by .9 cm, foam dressing applied. c. Left outer calf area cleansed, Silvasorb applied, a non-stick pad applied and area wrapped with Kling bandage. The DON failed to measure the left calf wound. 6. Resident #6 had a MDS with a reference date of 11/14/17. Resident #6 had diagnoses which included diabetes, stroke, and hemiplegia, cellulitis of left lower limb, venous insufficiency and cirrhosis of liver. The resident had a BIMS score of 15. A score of 15 reflected the resident had no cognitive problems. The resident required extensive assistance of 2 persons for bed mobility, toilet use and transfers. The MDS indicated the resident had a risk for developing pressure sores and had one Stage III pressure sore. Review of the Care Plan dated 9/12/17 revealed the resident had a venous stasis ulcer to his bilateral lower extremities and a pressure ulcer to the coccyx area. The Care Plan directed the staff to assess wound healing on a weekly basis, to	F 686		

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F 686	Continued From page 23 notify the physician with changes and complete dressings per physician's orders. According to the hospital re-admittance order dated 11/16/17, the physician directed the staff to irrigate the wound with saline bullet. Lightly pack ulcer with Alginate and cover with Mepilex border dressing. Review of the November and December Treatment Administration Records (TAR) directed the staff to cleanse the open area to coccyx area with wound spray, apply calcium AG (silver) to wound bed and cover with adhesive gauze. The December TAR reflected a change on 12/15/17, direct staff to use non- adhesive gauze to secure the gauze and with the remainder of the order remaining the same. Review of the November and December TAR revealed the staff failed to provide coccyx wound care on 11/4, 11/11, 11/18, 12/5, 12/6, 12/7 and 12/16/17. Review of the November and December treatment records revealed the staff provided the incorrect treatments from November 16-December 26, 2017. On 12/26/17 at 4:45 p.m., Staff B (registered nurse) was interviewed and reviewed the re-admission order dated 11/16/17. Staff B stated it directed staff to lightly pack the coccyx wound with Alginate and cover with Mepilex border. Staff B reviewed the November and December treatment records and admitted the order was transcribed incorrectly. The current TAR directed staff to cleanse coccyx wound and cover wound bed with non-adhesive gauze, it should have directed staff to lightly pack the coccyx wound with alginate and cover with Mepilex border	F 686		

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dressing. Staff B stated the staff had been doing the treatment incorrectly since 11/16/17.
Review of the Wound/Skin Healing Record, the resident developed a pressure ulcer to the coccyx on 1/2/17. The 11/10/17 assessment of the wound measured 0.7 cm by 0.4 cm and had a depth of 0.3 cm. According to the record this is the last measurement and indicated on 11/16/17 the resident experienced a hospitalization. The facility staff failed to re-assess the wound upon readmission to the facility. The D.O.N. measured the wound on 12/15/17 and the coccyx pressure wound measured 2.5 cm by 2.8 cm with 0.5 cm depth.

Observation on 12/15/17 at 11:30 a.m., staff transferred the resident to the commode and removed the coccyx dressing. The dressing removed had a date of 12/10/17, the responsible staff person who did not changing, failed to initial the dressing when they changed it.

Observations of the TAR revealed an agency nurse signed off the dressing changes from 12/11-12/14 which indicated she had completed the dressing changes.

During an interview with Staff C (certified medical assistant) on 12/16/17 at 5:00 p.m., the CMA stated she worked with the agency nurse responsible for Resident #6's dressing changes from 12/11-12/14. She stated at the end of the shift on 12/14/17 she stood near the nurse looking at the treatment records on the computer. Staff C stated all of the treatments were red which indicated they were not completed. The agency nurse stood and signed off all the treatments which indicated they were completed. Staff C stated she did not see the nurse do

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SUNNYCREST NURSING CENTER	401 CRISMAN STREET DYSART, IA 52224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25 treatments. Note: At the time of the investigation, it was determined this as an immediate jeopardy situation of health and safety. On 12/17/17 the facility had abated the situation by giving in-service training to the certified nursing assistants and nurses employed at the facility and agency staff and the scope and severity was lowered from a "K" to an "E" . The facility continued to need to: Continue to provide in-services to certified nursing assistants and nurses (including agency staff), Continue to monitor that pressure ulcers are prevented, assessed and treatment provided as ordered.	F 686		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced	F 727		

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F 727	Continued From page 26 by: Based on facility record review and staff interviews. the facility failed to provide registered nurse coverage for eight consecutive hours per day seven days a week and failed to employ a full time Director of Nurses. The facility census was 39 residents. Findings include: 1. Review of the Daily Nursing Assignment sheets dated 12/14/17 and 12/25/17 revealed the facility had a licensed practical, LPN nurse for coverage for those days with no registered nurse (RN) coverage as required. During interview on 12/27/17 at 8:44 a.m., the Administrator stated she was not aware of the lack of 8 hour RN coverage on 12/14 and 12/25/17. The Administrator was unable to find the Daily Nursing Assignment sheet for 12/15/17. The Administrator stated the facility did not have a Director of Nurses from 10/30/17 until December 11, 2017. During interview on 12/14/17 at 11:15 p.m., Staff E-Agency LPN, stated she has been working since 6:00 a.m. and worked double shifts this week from 6:00 a.m. until 10:00 p.m. Monday-Thursday. Staff E stated she had one resident who received skill nursing care. Observation on 12/14/17 at 10:48 p.m., revealed Staff D, LPN working the night shift into the morning of 12/15/17. Staff D stated she was the only nurse on for the night shift. During interview on 12/26/17 at 7:15 a.m., Staff F, LPN stated he relieved another LPN when he	F 727	F 727 The facility will provide registered nurse coverage for eight consecutive hours per day seven days a week and employ a full-time Director of Nurses. Facility will maintain the daily staffing sheets. Nursing staff in-serviced regarding the need for 8 hours RN coverage, DON requirements , and maintaining the daily staffing sheets on 12-29-17. DON and/or designee will complete routine audits on staffing sheets and RN coverage. The findings will be reported to the quarterly QAPI committee. Compliance 12-29-17	12-29-17

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F 727	Continued From page 27 arrived to work at 6:00 p.m. The day LPN worked from 6:00 a.m. on 12/25 until 10:00 p.m. on 12/25 and was relieved by Staff F who worked 6:00 p.m. until 10:00 a.m. on 12/26/17. During interview on 12/14/17 at 8:20 p.m., Staff B, RN stated the facility went for 6 weeks without a Director of Nurses and the former Administrator directed all staff to call him with issues, such as falls or unusual incidents.	F 727		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755	F 755 The facility will have 2 nurses completing narcotic count Nursing staff in-serviced on the policy regarding that 2 nurses to complete narcotic count on 12-29-17 DON and/or designee will complete routine audits regarding two nurses completing narcotic count. The findings of these audits will be reported to the facilities quarterly QAPI committee. Compliance Date: 1-15-18	1-15-18

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F 755	Continued From page 28 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, facility policy review and staff interview, the facility failed to have 2 nurses count narcotic medications to ensure accuracy of the count and as facility policy directed. The facility reported a census of 39 residents. Findings include: The North and South Narcotic sign off/count sheets documented the facility had 38 narcotic medications to account for. Review of the count sheets revealed 5 of the narcotics were dispensed in November 2017 with 33 narcotic medications dispensed in December 2017. Review of the narcotic count sheets revealed staff failed to have 2 nurses count the narcotics together 325 times from November 11 thru December 28, 2017. During interview on 12/28/17 at 8:30 a.m., Staff B, registered nurse, acknowledged two nurses do not routinely complete the narcotic count together. Review of an undated Controlled Medication Storage policy indicated at each shift change, a physical inventory of all scheduled II medications	F 755		

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F 755	Continued From page 29 was conducted by two licensed nurses and was documented on the controlled substances accountability record.	F 755		
F 836 SS=B	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.	F 836	F 836 The facility will complete annual performance reviews on employees. All staff in-serviced regarding the completion of annual performance reviews Administrator and/or designee will complete routine audits regarding the completion of annual performance reviews. The findings will be reported to the quarterly QAPI committee. Compliance Date:12-29-17	12-29-17

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F 836	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to complete annual performance reviews for 4 of 4 employees reviewed. The facility census was 39 residents. Findings include: Review of employee files revealed the following: a. Staff G, certified medication aide, CMA had a hire dated on 7/7/15, the employee file failed to contain a performance evaluation for 2017. b. Staff H, licensed practical nurse, LPN had a hire dated of 3/19/12, the employee file failed to contain a performance evaluation for 2017. c. Staff I, certified nurse aide, CNA had a hire date of 5/1/0/12, the employee file failed to contain a performance evaluation for 2017. d. Staff J, registered nurse, RN had a hire date of 11/3/15, the employee file failed to contain a performance evaluation for 2017. During interview on 12/28/17 at 11:09 a.m. the Business Office Manager stated she did not have any evaluations for 2017 for Staff G, Staff H, Staff I and Staff J.	F 836		