STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

(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 000	INITIAL COMMENTS Correction Date: ~~11/18/2020~~ Amended to 11/20/2020 T46 CK T20 A COVID-19 Focused Infection Control Survey was conducted 10/13/20 through 11/03/20, along with investigation of Complaints #91486, #91767, #93968 and a Facility Self-Reported Incident #93983. The facility was found to be in compliance with CMS and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Complaints #91767 and #94014 were substantiated and resulted in the following deficiencies. (See Code of Federal Regulations, (42 CFR), Subpart B-C). Facility Census: 48	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		

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

Tami Vigelu, LNHA — Administrator — 11/27/2020

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 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident responsible party (RP) interviews, the facility failed to notify the resident's RP of changes in resident conditions, for 3 of 9 resident records reviewed (Resident's #1, #4 and #8). The facility reported a census of 48 residents. Findings include:	F 580		

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F 580	Continued From page 2 1. The 7/31/20 Minimum Data Set (MDS) Assessment revealed Resident #1 had diagnoses that included non-Alzheimer's dementia, depression, cerebrovascular accident (a stroke), lack of coordination and hypertension (high blood pressure), scored 6 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated severe cognitive impairment, without symptoms of delirium, had verbal behaviors and rejected care from 1 to 3 days of the 7 days that preceded the assessment, required extensive assistance of at least 1 staff to reposition in bed and transfer to and from bed and chair, dressing, bathing, toileting and personal hygiene, had unclear speech and rarely/never able to make herself understood, able to understand others, and had adequate vision with the use of corrective lenses. The resident's record revealed she was admitted to the facility on 5/5/15, and a family member was the resident's legal responsible party (RP). An impaired cognitive function problem related to dementia on the Nursing Care Plan directed staff to communicate with the resident and family regarding the resident's capabilities and needs, and discuss concerns about confusion, disease process and nursing home placement with the resident and family. A Care Plan problem related to long term care placement without discharge plan directed staff to invite the resident and/or responsible party to care plan meetings as indicated. A psychiatric evaluation completed at the hospital on 10/13/20 revealed the resident caused a major incident at the nursing home because she	F 580		

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F 580	Continued From page 3	F 580		

needed her eye glasses, felt no one listened to her or cared, and acknowledged she felt frustrated without her glasses because she couldn't see things and wanted her glasses.

Staff interviews revealed:

10/22/20 at 8:56 a.m., Staff A, Certified Nursing Assistant (CNA) stated she had assisted the resident with cares and got her up on the morning of 10/10/20, the resident was in a bad mood and combative because she couldn't find her glasses. Staff A tried to reassure the resident and told her she thought they ordered a new pair for her but the resident wanted proof.

10/20/20 at 12:20 p.m., Staff B, Licensed Practical Nurse (LPN) stated on 10/10/20, she went in to administer the resident's morning medications and right away the resident was upset, worried about her eye glasses.

10/22/20 at 3:53 p.m., Staff C, LPN, stated the resident had behaviors, got mad, hit, kicked or barricaded herself in front of 1 of the doors when you reminded her to wear a mask when out of her room.

10/20/20 at 11:28 a.m., Staff D, Registered Nurse (RN) and Interim Director of Nursing (DON) stated over the last few weeks, the resident was focused on her lost glasses, everyone looked for them, they went through laundry and the kitchen on 10/8/20 and 10/9/20 without success. On the afternoon of 10/9/20 they discussed a return to the eye doctor to order a new pair. When the resident returned from the hospital on 10/14/20, her RP provided a pair of "cheater" glasses the resident used and worked until replacement

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F 580	Continued From page 4 glasses were available. 10/19/20 at 11:20 a.m., Staff E, RN, stated the resident was very upset because she couldn't see a few weeks ago and was sent to the ER, they thought she'd had a mini stroke, her vision had since returned. Staff E had heard the resident caused the 10/10/20 incident because she couldn't find her eye glasses. During an interview on 10/13/20 at 6:41 p.m., the Resident's RP stated the facility rarely notified them of changes in the resident's condition, expected to be notified of all changes, had addressed that with the facility in the past and little had changed. The RP was notified sometime over the summer the resident alleged a staff member had hit her on the back of her head, had not had any other contact until 9/28/20 when notified the resident was sent to the hospital with sudden vision changes, and on 10/10/20 when the resident was sent to the hospital again after she caused an incident at the facility. The RP was present in the hospital Emergency Room (ER) on 10/10/20 when the resident was questioned by a social worker, how they found out the resident was distraught because she had lost her eye glasses and thought staff at the facility didn't care. The RP stated the facility had not notified them of the missing eye glasses, or the resident's upset over it, and would have expected the facility to notify them of the information. 2. The 8/17/20 MDS Assessment tool revealed Resident #4 had diagnoses that included renal insufficiency, diabetes, thyroid disorder, atrial fibrillation (irregular heart beat) and dependence	F 580		

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F 580	Continued From page 5 on renal dialysis, scored 14 out of 15 points on the BIMS cognitive assessment, without symptoms of delirium, and required extensive assistance of 1 staff to reposition in bed and personal hygiene, and 2 staff assistance for transfers to and from bed and chair, toileting, bathing, the resident unable to ambulate, 1 Stage 1 pressure sore (intact skin with non-blanchable redness of a localized area), 5 venous or arterial skin ulcers, and pressure reduction devices in use for the chair and bed. Documentation revealed a family member was the resident's legal RP when the resident admitted to the facility on 8/6/20. An impaired skin integrity problem related to pressure injury initiated on the Care Plan on 8/10/20 directed staff to: a. On 8/10/20 perform treatment to wound per treatment order. b. On 8/10/20 follow pressure ulcer prevention guidelines to prevent additional skin problems. c. On 8/10/20 apply pressure reduction cushion to wheel chair. d. On 8/10/20 apply alternating pressure air mattress to bed, assure inflation control is correct. A revision on 10/13/20 stated the resident refused air mattress as ordered. Wound assessments documented 8/11/20 on Weekly Wound Observation V2 forms, reflected measurements obtained at the resident's 8/6/20 Wound Clinic (WC) appointment revealed: a. Wound #49, stasis ulcer left lower leg, 1.3 centimeters (cm) by 2.5 cm by 0.1 cm b. Wound #50, stasis ulcer right lateral lower leg, 9.5 cm by 2.0 cm by 0.1 cm c. Wound #51, Stage 3 pressure sore left posterior heel, 1.5 cm by 1.0 cm by 0.1 cm	F 580		

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F 580	Continued From page 6 d. Wound #54, stasis ulcer right proximal anterior lower leg, 8.9 cm by 6.0 cm by 0.1 cm e. Wound #55, Stage 3 pressure sore right posterior heel, 0.3 cm by 1.4 cm by 0.1 cm The WC physician directed care of the resident's wounds at weekly appointments. Wound #56, a new pressure sore on the left lateral thigh identified at the 8/27/20 WC appointment measured 3.7 cm by 2.2 cm by 0.7 cm. The other wounds assessed at the 8/27/20 WC appointment revealed: a. #49 0.6 cm by 1.2 cm by 0.1 cm b. #50 1.5 cm by 1.2 cm by 0.1 cm c. #51 1.4 cm by 1.7 cm by 0.1 cm d. #54 4.3 cm by 0.5 cm by 0.1 cm e. #55 0 cm by 0 cm by 0 cm. healed. The 9/3/20 WC appointment wound assessments revealed 3 new pressure sores and the following assessments: a. #49 3.4 cm by 1.9 cm by 0.1 cm b. #50 2.7 cm by 1.4 cm by 0.1 cm c. #51 2.2 cm by 1.3 cm by 0.2 cm d. #54 Healed e. #56, Stage 3 pressure sore of the left lateral thigh, 3.4 cm by 1.8 cm by 1.9 cm with tunneling. f. #57, Stage 1 pressure sore of the right medial buttocks, 0.4 cm by 0.4 cm by 0.1 cm g. #58, Stage 3 pressure sore of the left medial buttocks, 3.7 cm by 3.0 cm by 0.1 cm h. #59, deep tissue injury of the right lateral thigh with non-blanchable tissue. Physician Orders transcribed at the 9/3/20 WC appointment directed staff to evaluate the resident's wheel chair and room chair for size, might be cause of pressure sores to thighs, have resident assessed for Roho cushion (a pressure	F 580		

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F 580	Continued From page 7 relief wheel chair cushion), and resident to be out of wheel chair for pressure relief as much as possible. Wound measurements at the 9/10/20 WC appointment revealed: a. #49 0 cm by 0 cm by 0 cm healed b. #50 1.2 cm by 0.6 cm by 0.1 cm c. #51 1.6 cm by 1.6 cm by 0.2 cm d. #55 0 cm by 0 cm by 0 cm e. #56 3.3 cm by 1.6 cm by 1.6 cm, the wound tunneled f. #57 4.7 cm by 2.1 cm by 0.1 cm g. #58 5.0 cm by 4.0 cm by 0.1 cm h. #59 0 cm by 0 cm by 0 cm healed Physician orders transcribed at the 9/10/20 WC appointment directed staff to apply negative pressure wound therapy at 125 millimeters pressure to wound #56 via wound vac as soon as able, send black foam wound vac foam dressing package and canister with the resident to every WC appointment, use wheel chair cushion and mattress overlay or specialty bed for pressure relief. A Hospital ER progress note dated 10/9/20 revealed the resident transferred to the ER from her dialysis appointment for abdominal pain and resident report of no bowel movements for 6 or 7 days, and the physician removed a large fecal impaction. The resident's record did not reveal documentation of the RP's notification of the resident's condition changes. During an interview on 10/20/20, Staff D, Interim DON, stated the resident refused the air mattress	F 580		

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F 580	Continued From page 8 and remembered she notified the Nurse Practitioner who directed her to make sure the resident was on a pressure reduction mattress, she didn't know but didn't think the WC physician who ordered it was notified and didn't know if the RP was notified. During an interview 10/19/20 at 1:23 p.m., the resident's RP stated the facility had not notified them the resident's wounds had deteriorated and she had developed new pressure sores, or the resident transferred and treated at the ER for a fecal impaction. The resident had contacted another family member who notified the RP she was at the ER on 10/9/20. During another interview on 10/20/20 at 6:24 p.m., the RP denied that the facility had informed them the resident refused the air mattress, stated the facility should have notified them of the condition and treatment changes and they might have been able to discuss the matters with the resident and gained her support of the required interventions. 3. The 5/29/20 MDS Assessment tool revealed Resident #8 had diagnoses that included Huntington's Chorea, non-Alzheimer's dementia and depression, scored 14 out of 15 points possible on the BIMS cognitive assessment without symptoms of delirium, required assistance of at least 1 staff to transfer to and from bed and chair, ambulation and toileting, and extensive staff assistance for dressing, eating, bathing and personal hygiene, at risk for pressure sores and had 1 unstageable pressure that resulted from a deep tissue injury, height 5 foot 10 inches and weight 110 pounds which was a significant weight loss (5 percent in 1 month or 10 percent in 6 months) since the previous MDS	F 580		

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F 580	Continued From page 9 Assessment, and had experienced 2 or more falls without injury. A family member was identified as the resident's legal RP at the time of admission to the facility on 11/25/19. A Care Plan problem related to long term care placement without discharge plan directed staff to invite the resident and/or responsible party to care plan meetings as indicated. A Weekly Wound Observation V2 form completed 6/1/20 by Staff F, RN, facility Wound Nurse revealed a Stage 1 pressure sore that measured 3 centimeters (cm) by 3 cm by 0 cm depth that presented as a blanchable reddened area on the coccyx, the RP notified on 6/1/20 by a staff nurse. Nurse's note entries did not reveal the RP was notified of the pressure sore. A 6/1/20 physician order directed staff to cleanse the reddened coccyx area with normal saline, apply bordered foam pad or Mepilex, change every 3 days and as needed. V2 forms related to continued assessments of the pressure sore revealed: a. 6/8/20 - 1.5 cm by 1.5 cm by 0 depth, reddened blanchable area b. 6/15/20 - 1 cm by 1 cm by 0 cm c. 6/22/20 - 0.8 cm by 0.8 cm by 0 cm reddened blanchable area d. 6/29/20 - 0.6 cm by 0.3 cm by 0 cm A 6/28/20 Hospital ER progress note revealed the physician described a first degree pressure sore on the coccyx that required treatment with a soft foam dressing. During an interview on 10/14/20 at 7:29 p.m., the	F 580		

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F 580	Continued From page 10 resident's RP stated staff were supposed to notify them of any changes in the resident's condition but didn't do that. On 6/28/20, the RP was notified the resident required treatment in the hospital ER, the RP was present with the resident when the ER physician notified them of the coccyx pressure sore. The RP stated they were very upset, the facility had not notified them of the pressure sore or required treatment and expected them to do that. On 10/15/20 at 1:31 p.m., Staff G, RN from the resident's Hospice program stated she had completed weekly assessments of the resident until May, 2020 when the facility would not permit their continued assessments and resident support despite the resident's decline. She contacted facility staff weekly for updates, on 6/11/20 facility staff informed her the resident had a coccyx pressure sore that measured 1.5 cm by 1.5 cm and a Mepilex dressing ordered for protection. On 6/23/20 the facility reported the pressure sore had healed. On 7/3/20 the resident discharged from the facility, Hospice continued services for the resident and his family, there was a pressure sore on his coccyx that measured 0.3 cm by 0.2 cm by 0.1 cm depth, and the sore was healed within a week by care from the family and hospice staff. The facility had not notified the RP of the pressure sore as indicated by her conversations with the RP.	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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F 684	Continued From page 11 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, Wound Center staff and physician interviews, the facility failed to provide nursing care in accordance to professional standards of practice that included Care Plan development, implementation of and following physician orders for wound care and pressure sore reduction, bowel management regimen's, and resulted in a resident's treatment at a hospital Emergency Room (ER) and hospitalization for 1 of 9 resident records reviewed (Resident #4). The facility reported a census of 48 residents. Findings include: The 8/17/20 MDS Assessment tool revealed Resident #4 admitted to the facility on 8/6/20, had diagnoses that included renal insufficiency, diabetes, thyroid disorder, atrial fibrillation (irregular heart beat) and dependence on renal dialysis, scored 14 out of 15 points on the BIMS cognitive assessment, without symptoms of delirium, and required extensive assistance of 1 staff to reposition in bed and personal hygiene, and 2 staff assistance for transfers to and from bed and chair, toileting, bathing, the resident unable to ambulate, 1 Stage 1 pressure sore (intact skin with non-blanchable redness of a localized area), 5 venous or arterial skin ulcers, and pressure reduction devices in use for the chair and bed. The Care Area Assessment (CAA) Summary of the MDS Assessment	F 684		

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F 684	Continued From page 12 identified dehydration and fluid maintenance as a potential problem that required address on the resident's care plan. An impaired skin integrity problem related to pressure injury initiated on the care plan on 8/10/20 directed staff to: a. On 8/10/20 perform treatment to wound per treatment order. b. On 8/10/20 follow pressure ulcer prevention guidelines to prevent additional skin problems. c. On 8/10/20 apply pressure reduction cushion to wheel chair. d. On 8/10/20 apply alternating pressure air mattress to bed, assure inflation control is correct. A revision on 10/13/20 stated the resident refused air mattress as ordered. The resident's Care Plan did not address actual or potential dehydration or fluid maintenance problems or interventions as required. Wound assessments documented 8/11/20 on Weekly Wound Observation V2 forms, reflected measurements obtained at the resident's 8/6/20 Wound Clinic (WC) appointment: a. Wound #49, stasis ulcer left lower leg, 1.3 centimeters (cm) by 2.5 cm by 0.1 cm b. Wound #50, stasis ulcer right lateral lower leg, 9.5 cm by 2.0 cm by 0.1 cm c. Wound #51, Stage 3 pressure sore left posterior heel, 1.5 cm by 1.0 cm by 0.1 cm d. Wound #54, stasis ulcer right proximal anterior lower leg, 8.9 cm by 6.0 cm by 0.1 cm e. Wound #55, Stage 3 pressure sore right posterior heel, 0.3 cm by 1.4 cm by 0.1 cm The WC physician directed care of the resident's wounds at weekly appointments. Wound	F 684		

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F 684	Continued From page 13 assessments at the 8/27/20 WC appointment revealed: a. #49 0.6 cm by 1.2 cm by 0.1 cm b. #50 1.5 cm by 1.2 cm by 0.1 cm c. #51 1.4 cm by 1.7 cm by 0.1 cm d. #54 4.3 cm by 0.5 cm by 0.1 cm e. #55 0 cm by 0 cm by 0 cm. healed f. #56 Newly identified pressure sore on the left lateral thigh, 3.7 cm by 2.2 cm by 0.7 cm The 9/3/20 WC appointment wound assessments revealed 3 new pressure sores and the following assessments: a. #49 3.4 cm by 1.9 cm by 0.1 cm b. #50 2.7 cm by 1.4 cm by 0.1 cm c. #51 2.2 cm by 1.3 cm by 0.2 cm d. #54 Healed e. #56, Stage 3 pressure sore of the left lateral thigh, 3.4 cm by 1.8 cm by 1.9 cm with tunneling. f. #57, Stage 1 pressure sore of the right medial buttocks, 0.4 cm by 0.4 cm by 0.1 cm g. #58, Stage 3 pressure sore of the left medial buttocks, 3.7 cm by 3.0 cm by 0.1 cm h. #59, deep tissue injury of the right lateral thigh with non-blanchable tissue. Physician orders transcribed at the 9/3/20 WC appointment directed staff to evaluate the resident's wheel chair and room chair for size due to pressure sores on resident thighs, have resident assessed for Roho cushion (a pressure relief wheel chair cushion), resident to be out of wheel chair for pressure relief as much as possible. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. Wound measurements at the 9/10/20 WC appointment revealed:	F 684		

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F 684	Continued From page 14 a. #49 0 cm by 0 cm by 0 cm healed b. #50 1.2 cm by 0.6 cm by 0.1 cm c. #51 1.6 cm by 1.6 cm by 0.2 cm d. #55 0 cm by 0 cm by 0 cm e. #56 3.3 cm by 1.6 cm by 1.6 cm, the wound tunneled f. #57 4.7 cm by 2.1 cm by 0.1 cm g. #58 5.0 cm by 4.0 cm by 0.1 cm h. #59 0 cm by 0 cm by 0 cm healed Other wound care orders transcribed at the 9/10/20 WC appointment included: a. #50 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Polymems dressing, cover dressing with rolled gauze and secure with tape 3 times per week and as needed. b. #51 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Mepilex or similar dressing, cover dressing with rolled gauze and secure with tape 3 times per week and as needed. c. #55 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Mepilex or similar dressing, cover dressing with rolled gauze and secure with tape 3 times per week and as needed. d. #56 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply hydrofera blue lightly packed into the wound, use until wound vac is able to be placed in wound. Cover wound with Optifoam or similar dressing, secure dressing in place. Arrange to start negative pressure wound therapy at 125 millimeters pressure, change dressing 3 times per week. Send a black foam dressing package and wound vac canister with the resident to every WC appointment. e. #57 Cleanse wound and periwound with	F 684		

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F 684	Continued From page 15 non-cytotoxic agent such as normal saline, apply Allevyn or comparable sacral dressing, change every other day and as needed. f. #58 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Allevyn or comparable sacral dressing, change every other day and as needed. g. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. WC orders transcribed at the 9/17/20 appointment directed staff: a. Resident needs wider wheel chair, causing pressure sores to thighs. b. Have resident assessed for Roho cushion. c. Apply a barrier cream to right thigh. d. Administer Cefdinir 300 mg oral every other day for 1 week. e. Do not turn the wound vac off overnight as that can cause an infection, wound infection suspected due to odor of wound #56 and resident's report the wound vac was turned off. f. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. 9/24/20 WC physician orders directed staff: a. Send a black foam dressing package and wound vac canister with the resident to every WC appointment. WC applied Hydrofera blue to wound #56 due to the facility did not provide the required wound vac supplies. Remove the Hydrofera blue and apply wound vac, place tube going across the resident's anterior thigh to prevent further pressure sores. b. Resident needs wider wheel chair, still causing pressure sores to thighs. c. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress.	F 684		

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F 684	Continued From page 16 10/1/20 WC physician orders directed staff: a. #51 Apply alginate then Mepilex, cover with rolled gauze and secure with tape 3 times weekly and as needed. b. #56 Send a black foam dressing package and wound vac canister with the resident to every WC appointment. WC applied Hydrofera blue to wound #56 due to the facility did not provide the required wound vac supplies. Remove the Hydrofera blue and apply wound vac, place tube going across the resident's anterior thigh to prevent further pressure sores. c. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. The September, 2020 Treatment Administration Records (TAR's) revealed staff did not administer wound care as ordered to wounds #50, #54, #55, and #56 on 9/10/20, 9/12/20, 9/15/20, 9/17/20, 9/19/20, 9/22/20, 9/26/20, and 9/29/20, and treatments to wounds #57 and #58 not administered 9/15/20, 9/19/20, and 9/29/20. The October, 2020 TAR's revealed staff did not administer wound care as ordered to wounds #50, #51, #54, #57 and #58 on 10/6/20, 10/8/20, 10/10/20 and 10/13/20. Medication orders transcribed 8/6/20 included the following bowel medications: a. Bisacodyl 10 milligrams (mg) administered rectal every 24 hours as needed for constipation. b. Docusate Sodium 100 mg administered oral daily. c. Polyethylene Glycol 3350 powder 17 Grams administered oral daily. d. Senna 8.6 mg administered oral every other day.	F 684		

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F 684	Continued From page 17 The resident's October elimination records, reviewed 10/20/20 revealed no documentation of a bowel movement between 10/1/20 and 10/12/20 on paper records, and no recorded bowel movement between 10/13/20 and 10/19/20 on electronic records initiated on 10/12/20. The October, 2020 Medication Administration Record (MAR) revealed staff had not administered Bisacodyl. A Hospital ER Progress Note dated 10/9/20 revealed the resident transferred to the ER from her dialysis appointment due to abdominal pain and the resident reported no bowel movements for 6 or 7 days, the physician removed a large fecal impaction. A Progress Note transcribed by the Nurse Practitioner on 10/13/20 at 5:30 p.m. described a right lower extremity wound maggot infestation and purulent discharge with associated erythema, and the resident transferred to the ER for evaluation. When interviewed on 10/27/20 at 9:58 a.m., the resident stated the length of time between her wound care/dressing changes seemed like it was longer than every other day and sometimes she had to ask staff to do her dressing changes or remind them. She knew there were maggots in 1 of her wounds but didn't know that happened, the facility put her in a wheel chair that wasn't wide enough, that caused pressure and how she got some of the pressure sores on her thighs, the facility got her a different wheel chair, it could still stand to be wider because if she's not seated just right it felt tight on her hips/upper legs.	F 684		

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F 684	Continued From page 18 Staff interviews revealed: 10/20/20 at 12:20 p.m., Staff B, Licensed Practical Nurse (LPN) stated staff were supposed to follow physician orders for dressing changes, if staff can't complete the dressing change it is passed on to the next shift, dressings should be dated and initialed. When she found dressings that hadn't been changed for several days she used to take a photo of it and took it to the former Director of Nursing (DON), but nothing happened. If staff hadn't changed the dressings for several days it should be reported to the physician. 10/22/20 at 3:53 p.m. Staff C, LPN stated if a resident's dressings aren't changed as ordered, would report it to the DON. When asked why the resident's dressings had not been changed between 10/3/20 and 10/13/20, Staff C stated the resident went to a doctor appointment on 10/8/20 so missed WC appointment, normally staff changed the dressings upon the return from dialysis but dialysis sent the resident to the ER on 10/9/20, and there was a fire at the facility on 10/10/20. Nurses were supposed to ask the certified nursing assistants (CNA's) about resident's bowel patterns daily. 10/20/20 at 4:53 p.m., Staff E, Registered Nurse (RN), stated normally the resident's dressings were changed at the WC during her weekly appointment there. The resident was scheduled for the WC on 10/13/20, a therapist saw a maggot on 1 of the resident's wounds and got the DON. The DON completed the dressing change for that wound, got orders to send the resident to the ER, so Staff E changed all the other dressings except for the wound vac, the dressings hadn't been changed since 10/3/20, the	F 684		

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F 684	Continued From page 19 resident didn't usually refuse care but might request that staff complete it at a later time. 10/20/20 at 11:35 a.m., Staff F, RN, the facility Wound Nurse stated nurses should sign dressings they applied with date, time and initials, that is standard protocol. If a nurse finds dressings that aren't changed as ordered they should report it to the physician and for certain the DON. If a WC physician wrote orders or made suggestions such as Roho cushion or mattress overlay, staff should read and understand that, address the orders with the DON and the resident's physician if equipment was required. 10/21/20 at 6:58 p.m., Staff K, RN stated staff should complete dressing changes and treatments as ordered, and should notify the DON if they found dressings that haven't been changed. Nurses are responsible for monitoring resident's bowel status, the certified nursing assistants (CNA's) document the resident's bowel movements, the records are accessible to the nurse and a place for it on the TAR. 10/22/20 at 4:10 p.m., Staff I, RN from the resident's WC stated she was present at the resident's 9/10/20 appointment, resident was in a wheel chair that was wider than her previous appointments, but the physician said it wasn't big enough, she had a wheel chair cushion but not the Roho cushion the physician had ordered, the resident had the wound vac on but the facility hadn't sent the required supplies for the dressing change. The resident was concerned that facility staff didn't change her dressings correctly, or as often as ordered, said she had to ask staff to change them and staff would leave her up in the	F 684		

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F 684	Continued From page 20 wheel chair too long. The WC staff didn't feel the resident received appropriate care, she had more wounds and her other wounds were worse. 10/29/20 at 8:40 a.m., Staff J, WC Physician, stated he had several concerns about the resident's wound care at the facility, sometimes the dressings removed at the WC were not as they had ordered, the resident was in a wheel chair that was too small, it was easy to see where the sides of the wheel chair under the arm rests pushed on her thighs and exactly where she developed pressure sores on her bilateral thighs, this went on for weeks. The resident developed another pressure sore from the wound vac tubing that wasn't bridged on her anterior thigh as directed, the facility didn't send the required wound vac sponges and supplies with the resident to her WC appointments as ordered and standard protocol at least 3 times, and staff were leaving her up in the wheel chair and not off-loading her pressure areas, also directed in his orders.. The physician was not aware the resident refused the air mattress, and staff should have notified him of that condition. During an interview on 10/20/20, at 11:28 a.m., Staff D, Interim DON, stated staff should follow physician orders, if they can't they should contact the physician for direction and new orders, it was not acceptable for staff not to complete treatments and that should be reported to the DON or administrator. Staff D reviewed the resident's September and October TAR, agreed treatments were missing, and she started audits of MAR's and TAR's a week ago. Staff D was not aware that the resident's treatments weren't done and not sure why staff hadn't reported it. During an interview on 10/20/20 at 2:48 p.m., Staff D	F 684		

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F 684	Continued From page 21 stated the nurse is responsible for monitoring resident bowel function, they should check the ADL book (activities of daily living), and since 10/12/20 the information is documented in the electronic record. There were some standing orders for bowel protocols, and the nurse should call the physician for orders when needed. Staff D reviewed the resident's October bowel records and could not identify when the resident had a bowel movement in October, knew dialysis had sent the resident to the ER 10/9/20 because she needed an enema, and could not identify any action that she had taken as the interim DON to address the issue with the staff. During an interview on 10/20/20 at 3:46 p.m., Staff D stated the resident refused an air mattress and provided a copy of the Care Plan where it was documented, remembered she told the nurse practitioner about it and she said to ensure the resident was on a pressure reduction mattress. She didn't know but didn't think the WC Physician was notified about it. During the Exit Conference on 11/3/20, facility staff present that included the Administrator, Staff D; Interim DON, the Admissions Nurse and the Infection Control Nurse could not answer why nursing staff had not changed the resident's dressings for 10 days, but have since educated staff, implemented protocols and initiated audits for documentation and treatments are administered as ordered.	F 684		
F 686 SS=G	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 22 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, record review, resident, resident responsible party (RP), staff, Wound Center staff and physician interviews, the facility failed to prevent the development of new pressure sores and failed to prevent worsening of existing pressure sores for 1 of 3 residents with pressure sores records reviewed (Resident #4). The facility reported a census of 48 residents. Findings include: The 8/17/20 MDS Assessment tool revealed Resident #4 had diagnoses that included renal insufficiency, diabetes, thyroid disorder, atrial fibrillation (irregular heart beat) and dependence on renal dialysis, scored 14 out of 15 points on the BIMS cognitive assessment, without symptoms of delirium, and required extensive assistance of 1 staff to reposition in bed and personal hygiene, and 2 staff assistance for transfers to and from bed and chair, toileting, bathing, the resident unable to ambulate, 1 Stage 1 pressure sore (intact skin with non-blanchable redness of a localized area), 5 venous or arterial skin ulcers, and pressure reduction devices in	F 686		

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F 686	Continued From page 23 use for the chair and bed. The resident was admitted to the facility on 8/6/20, transferred there from another long-term care facility. An impaired skin integrity problem related to pressure injury initiated on the Care Plan on 8/10/20 directed staff to: a. On 8/10/20 perform treatment to wound per treatment order. b. On 8/10/20 follow pressure ulcer prevention guidelines to prevent additional skin problems. c. On 8/10/20 apply pressure reduction cushion to wheel chair. d. On 8/10/20 apply alternating pressure air mattress to bed, assure inflation control is correct. A revision on 10/13/20 stated the resident refused air mattress as ordered. Wound assessments documented 8/11/20 on Weekly Wound Observation V2 forms, reflected measurements obtained at the resident's 8/6/20 Wound Clinic (WC) appointment: a. Wound #49, stasis ulcer left lower leg, 1.3 Centimeters (cm) by 2.5 cm by 0.1 cm b. Wound #50, stasis ulcer right lateral lower leg, 9.5 cm by 2.0 cm by 0.1 cm c. Wound #51, Stage 3 pressure sore left posterior heel, 1.5 cm by 1.0 cm by 0.1 cm d. Wound #54, stasis ulcer right proximal anterior lower leg, 8.9 cm by 6.0 cm by 0.1 cm e. Wound #55, Stage 3 pressure sore right posterior heel, 0.3 cm by 1.4 cm by 0.1 cm The WC Physician directed care of the resident's wounds at weekly appointments. Wound assessments at the 8/27/20 WC appointment revealed: a. #49 0.6 cm by 1.2 cm by 0.1 cm b. #50 1.5 cm by 1.2 cm by 0.1 cm	F 686		

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F 686	Continued From page 24 c. #51 1.4 cm by 1.7 cm by 0.1 cm d. #54 4.3 cm by 0.5 cm by 0.1 cm e. #55 0 cm by 0 cm by 0 cm. healed f. #56 Newly identified pressure sore on the left lateral thigh, 3.7 cm by 2.2 cm by 0.7 cm The 9/3/20 WC appointment wound assessments revealed 3 new pressure sores and the following assessments: a. #49 3.4 cm by 1.9 cm by 0.1 cm b. #50 2.7 cm by 1.4 cm by 0.1 cm c. #51 2.2 cm by 1.3 cm by 0.2 cm d. #54 Healed e. #56, Stage 3 pressure sore of the left lateral thigh, 3.4 cm by 1.8 cm by 1.9 cm with tunneling. f. #57, Stage 1 pressure sore of the right medial buttocks, 0.4 cm by 0.4 cm by 0.1 cm g. #58, Stage 3 pressure sore of the left medial buttocks, 3.7 cm by 3.0 cm by 0.1 cm h. #59, deep tissue injury of the right lateral thigh with non-blanchable tissue. Physician Orders transcribed at the 9/3/20 WC appointment directed staff to evaluate the resident's wheel chair and room chair for size due to pressure sores on resident thighs, have resident assessed for Roho cushion (a pressure relief wheel chair cushion), resident to be out of wheel chair for pressure relief as much as possible. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. Wound measurements at the 9/10/20 WC appointment revealed: a. #49 0 cm by 0 cm by 0 cm healed b. #50 1.2 cm by 0.6 cm by 0.1 cm c. #51 1.6 cm by 1.6 cm by 0.2 cm d. #55 0 cm by 0 cm by 0 cm	F 686		

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F 686	Continued From page 25 e. #56 3.3 cm by 1.6 cm by 1.6 cm, the wound tunneled f. #57 4.7 cm by 2.1 cm by 0.1 cm g. #58 5.0 cm by 4.0 cm by 0.1 cm h. #59 0 cm by 0 cm by 0 cm healed Other wound care orders transcribed at the 9/10/20 WC appointment included: a. #50 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Polymems dressing, cover dressing with rolled gauze and secure with tape 3 times per week and as needed. b. #51 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Mepilex or similar dressing, cover dressing with rolled gauze and secure with tape 3 times per week and as needed. c. #55 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Mepilex or similar dressing, cover dressing with rolled gauze and secure with tape 3 times per week and as needed. d. #56 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply hydrofera blue lightly packed into the wound, use until wound vac is able to be placed in wound. Cover wound with Optifoam or similar dressing, secure dressing in place. Arrange to start negative pressure wound therapy at 125 millimeters pressure, change dressing 3 times per week. Send a black foam dressing package and wound vac canister with the resident to every WC appointment. e. #57 Cleanse wound and periwound with non-cytotoxic agent such as normal saline, apply Allevyn or comparable sacral dressing, change every other day and as needed. f. #58 Cleanse wound and periwound with	F 686		

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F 686	Continued From page 26 non-cytotoxic agent such as normal saline, apply Allevyn or comparable sacral dressing, change every other day and as needed. g. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. The 9/17/20 WC Physician progress note described the following wound conditions: a. #50 - 2.5 cm by 0.5 cm by 0.1 cm, adipose exposed, moderate amount of sero-sanguineous drainage, wound pain level of 5/10 (0 to 10 pain scale with 10 identified as worst pain). b. #51 - 1.5 cm by 1.0 cm by 0.2 cm, adipose exposed, moderate sero-sanguineous drainage, wound pain level 6/10. c. #55 - 0 cm by 0 cm d. #56 - 3.1 cm by 2.8 cm by 1.6 cm, adipose exposed, undermining present, moderate sero-sanguineous drainage, wound pain level 5/10. e. #57 - 1.6 cm by 1.0 cm by 0.1 cm, adipose exposed, moderate sero-sanguineous drainage, wound pain level 6/10. f. #58 - 4.8 cm by 4.0 cm by 0.1 cm, moderate amount sero-sanguineous drainage, wound pain level 7/10. WC orders transcribed at the 9/17/20 appointment directed staff: Resident needs wider wheel chair, causing pressure sores to thighs. Have resident assessed for Roho cushion. Apply a barrier cream to right thigh. Administer Cefdinir 300 mg oral every other day for 1 week. Do not turn the wound vac off overnight as that can cause an infection, wound infection suspected due to odor of wound #56 and resident's report the wound vac was turned off.	F 686		

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F 686	Continued From page 27 Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. 9/24/20 WC physician orders directed staff: a. Send a black foam dressing package and wound vac canister with the resident to every WC appointment. WC applied Hydrofera blue to wound #56 due to the facility did not provide the required wound vac supplies. Remove the Hydrofera blue and apply wound vac, place tube going across the resident's anterior thigh to prevent further pressure sores. b. Resident needs wider wheel chair, still causing pressure sores to thighs. c. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. The 10/1/20 WC wound assessments revealed: a. #50 - 7.5 cm by 2.0 cm by 0.1 cm, moderate sero-sanguineous drainage b. #51 - 1.0 cm by 1.2 cm by 0.2 cm, moderate sero-sanguineous drainage c. #55 - 1.0 cm by 1.2 cm by 0.1 cm, scabbed over d. #56 - 2.4 cm by 2.0 cm by 1.4 cm, tunneled, moderate sero-sanguineous drainage e. #57 - 5.0 cm by 2.5 cm by 0.1 cm, moderate sero-sanguineous drainage f. #58 - 1.0 cm by 1.5 cm by 0.1 cm, scant sero-sanguineous drainage 10/1/20 WC Physician orders directed staff: a. #51 Apply alginate then Mepilex, cover with rolled gauze and secure with tape 3 times weekly and as needed. b. #56 Send a black foam dressing package and wound vac canister with the resident to every WC appointment. WC applied Hydrofera blue to	F 686		

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F 686	Continued From page 28 wound #56 due to the facility did not provide the required wound vac supplies. c. Remove the Hydrofera blue and apply wound vac, place tube going across the resident's anterior thigh to prevent further pressure sores. d. Use wheel chair cushion and mattress overlay or specialty bed or pressure relief mattress. The September, 2020 Treatment Administration Records (TAR's) revealed staff did not administer wound care as ordered to wounds #50, #54, #55, and #56 on 9/10/20, 9/12/20, 9/15/20, 9/17/20, 9/19/20, 9/22/20, 9/26/20, and 9/29/20, and treatments to wounds #57 and #58 not administered 9/15/20, 9/19/20, and 9/29/20. The October, 2020 TAR's revealed staff did not administer wound care as ordered to wounds #50, #51, #54, #57 and #58 on 10/6/20, 10/8/20, 10/10/20 and 10/13/20. A Progress Note transcribed by the Nurse Practitioner on 10/13/20 at 5:30 p.m. described a right lower extremity wound maggot infestation, purulent discharge with associated erythema, and the resident transferred to the ER in her wheel chair via facility van for evaluation. The 10/13/20 ER Progress Note described the resident treated for presence of maggots in a right lower extremity wound and hospitalized for treatment of cellulitis. A 10/21/20 Hospital Progress Note described the resident treated for purulent cellulitis, wound cultures grew Klebsiella pneumonia, Methicillin Resistant Staphylococcus Aureus (MRSA) Providencia that required antibiotic treatment with Ceftriaxone, Doxycycline, Ceftriaxone and	F 686		

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F 686	Continued From page 29 Vancomycin, Infectious Disease specialist consulted and recommended deescalating to Omnicef and Linezolid antibiotics, initiated on 10/19/20. The last wound culture collected 8/28/20 at the WC revealed heavy growth Enterococcus faecalis (probably skin flora), heavy growth Peptostreptococcus, and heavy growth Prevotella species. When interviewed on 10/27/20 at 9:58 a.m., the resident stated the length of time between her wound care/dressing changes seemed like it was longer than every other day and sometimes she had to ask staff to do her dressing changes or remind them. She knew there were maggots in 1 of her wounds but didn't know that happened, the facility put her in a wheel chair that wasn't wide enough, that caused pressure and how she got some of the pressure sores on her thighs, the facility got her a different wheel chair, it could still stand to be wider because if she's not seated just right it felt tight on her hips/upper legs. Observation in the resident's room on 10/19/20 at 1:28 p.m. revealed a gray and navy blue mattress on the resident's bed, a tag on the mattress read "Medacure" Model PX8036, Prototype ID PX8000. Observation with Staff D, the Interim Director of Nursing (DON) on 10/20/20 at 4:59 p.m. in the resident's room revealed the resident's cam boot on the floor, next to a black wheel chair cushion approximately 2 to 3 inches thick also on the floor. Staff D unzipped the cushion cover that revealed a Roho type of rubber seat inside the cover, without name on the cover.	F 686		

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F 686	Continued From page 30 Hospital staff confirmed the resident arrived via wheel chair on 10/13/20, a black wheel chair seat foam cushion approximately 1 inch thick in the wheel chair. The resident's RP, interviewed 10/20/20 at 7:33 p.m. confirmed the resident had a wheel chair that was located at her home, she hadn't brought it to the facility. Staff interviews revealed: 10/20/20 at 12:20 p.m., Staff B, Licensed Practical Nurse (LPN) stated staff were supposed to follow physician orders for dressing changes, if staff can't complete the dressing change it is passed on to the next shift, dressings should be dated and initialed. When she found dressings that hadn't been changed for several days she used to take a photo of it and took it to the former DON, but nothing happened. If staff hadn't changed the dressings for several days it should be reported to the physician. 10/22/20 at 3:53 p.m. Staff C, LPN stated if a resident's dressings aren't changed as ordered, would report it to the DON. When asked why the resident's dressings had not been changed between 10/3/20 and 10/13/20, Staff C stated the resident went to a doctor appointment on 10/8/20 so missed WC appointment, normally staff changed the dressings upon the return from dialysis but dialysis sent the resident to the ER on 10/9/20, and there was a fire at the facility on 10/10/20. 10/20/20 at 4:53 p.m., Staff E, Registered Nurse (RN), stated normally the facility did not provide	F 686		

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F 686	Continued From page 31	F 686		

wound care on days the resident was scheduled at the WC, the resident was scheduled for her weekly appointment on 10/13/20. A facility therapist saw a maggot on 1 of the resident's wounds on 10/13/20 and got the DON. The DON completed the dressing change for that wound, got orders to send the resident to the ER, so Staff E changed all the other dressings except for the wound vac, the dressings hadn't been changed since 10/3/20, the resident didn't usually refuse care but might request that staff complete it at a later time.

10/20/20 at 11:35 a.m., Staff F, RN, the facility wound nurse stated nurses should sign dressings they applied with date, time and initials, that is standard protocol. If a nurse found dressings that weren't changed as ordered they should report it to the physician and for certain the DON. If a WC physician wrote orders or made suggestions such as Roho cushion or mattress overlay, staff should read and understand that, address the orders with the DON and the resident's physician if equipment was required.

10/21/20 at 6:58 p.m., Staff K, RN stated staff should complete dressing changes and treatments as ordered, and should notify the DON if they found dressings that haven't been changed.

10/22/20 at 4:10 p.m., Staff I, RN from the resident's WC stated she was present at the resident's 9/10/20 appointment, resident was in a wheel chair that was wider than her previous appointments, but the physician said it wasn't big enough, she had a wheel chair cushion but not the Roho cushion the physician had ordered, the resident had the wound vac on but the facility

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F 686	Continued From page 32	F 686		

hadn't sent the required supplies for the dressing change. The resident was concerned that facility staff didn't change her dressings correctly, or as often as ordered, said she had to ask staff to change them and staff would leave her up in the wheel chair too long. The WC staff didn't feel the resident received appropriate care, she had more wounds and her other wounds were worse.

10/29/20 at 8:40 a.m., Staff J, WC Physician, stated he had several concerns about the resident's wound care at the facility, sometimes the dressings removed at the WC were not as they had ordered, the resident was in a wheel chair that was too small, it was easy to see where the sides of the wheel chair under the arm rests pushed on her thighs and exactly where she developed pressure sores on her bilateral thighs, this went on for weeks. The resident developed another pressure sore from the wound vac tubing that wasn't bridged on her anterior thigh as directed, the facility didn't send the required wound vac sponges and supplies with the resident to her WC appointments as ordered and standard protocol at least 3 times, and staff were leaving her up in the wheel chair and not off-loading her pressure areas, also directed in his orders.. The physician was not aware the resident refused the air mattress, and staff should have notified him of that condition.

10/21/20 at 1:54 p.m., Staff N, Administrator at another facility that transferred the resident to the current facility on 8/6/20 stated the resident was discharged from their facility without durable medical equipment (DME) requirements, and her facility had not purchased a wheel chair or wheel chair seat cushion for the resident.

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F 686	Continued From page 33 During an interview on 10/20/20 at 4:59 p.m., Staff D stated a therapist came and got her on 10/13/20, saw a maggot that fell off the resident's lower leg and came to her. Staff D went to the room with staff M, LPN, ADON and the Nurse Practitioner. Staff D stated there were at least 20 maggots in a wound on the resident's right lateral lower leg, she flushed the wound, the nurse practitioner dressed the wound and ordered the resident's transfer to the ER. 10/21/20 at 9:07 a.m. Staff H, Physical Therapy Assistant (PTA) stated on 10/13/20 when she raised the right lower leg a maggot fell out from the dressing, the dressing was loose on the bottom, she lowered the resident's leg and reported it to Staff D immediately. During an interview on 10/20/20 at 3:46 p.m., Staff D stated the resident refused an air mattress and provided a copy of the care plan where it was documented, remembered she told the nurse practitioner about it and she said to ensure the resident was on a pressure reduction mattress. She didn't know but didn't think the WC Physician was notified about it. During an interview on 10/20/20, at 11:28 a.m., Staff D, interim DON, stated staff should follow Physician Orders, if they can't they should contact the physician for direction and new orders, it was not acceptable for staff not to complete treatments and that should be reported to the DON or administrator. Staff D reviewed the resident's September and October TAR, agreed treatments were missing, and she started audits of MAR's and TAR's a week ago. Staff D was not aware that the resident's treatments weren't done and not sure why staff hadn't reported it.	F 686		

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F 686	Continued From page 34 During the Exit Conference on 11/3/20, facility staff present that included the Administrator, Staff D; Interim DON, the Admissions Nurse and the Infection Control Nurse could not answer why nursing staff had not changed the resident's dressings for 10 days, but have since educated staff, implemented protocols and initiated audits for documentation and treatments are administered as ordered.	F 686		

Plan of Correction
Bettendorf Health Care Center
2730 Crow Creek Road
Bettendorf, Iowa 52722
Survey: October 13, 2020 – November 3, 2020
Correction Date: 11/18/2020

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

F580 Notification of Changes

1. How the deficiency will be corrected as it relates to R1, R4 and R8:
   a. DON or Designee in-serviced staff on Completing Notification & Documentation of physician and/or resident representative with any change in condition according to Notification of Change of Condition per policy on October 13, 2020 and on November 6, 2020. (See Attachment A).
2. All residents have the potential to be affected by this deficient practice.
3. Measures taken or systems altered to ensure the problem does not reoccur:
   a. ADON and/ or Admissions RN completed in-service with nursing staff on completing documentation and notification on Change in Condition on October 13, 2020 and November 6, 2020. (See Attachment A)
4. Monitoring of performance to ensure solutions are permanent:
   a. DON or Designee will monitor through facility audit tool for changes of resident's condition to ensure notification of physician and/or resident's representative weekly for 6 weeks & then monthly to ensure ongoing compliance. Findings will be reported to monthly QAPI. (See Attachment B1 and B2)
5. **Date of compliance: November 12, 2020**

F684 Quality of Care

1. How the deficiency will be corrected as it relates to R4:
   a. R4 returned from the hospital on November 2, 2020. R4s care plan and interventions were reviewed related to bowel program and pressure ulcer interventions and treatments to ensure physician orders being followed on November 3, 2020.
   b. DON/Designee completed in-service with Licensed Nursing staff on following physicians orders for wound care / pressure sore reduction on October 19, 2020. (See Attachment C)
   c. DON/ Designee completed in-service with Licensed Nursing staff on Monitoring Bowel Management Regimen on October 21, 2020. (See Attachment D)
   d. DON/Designee completed in-service with CNA's Regarding Appropriate Documentation of Bowel Movements and Point of Care Charting. (See Attachment E).

2. All residents have the potential to be affected by this deficient practice.
3. Measures taken or systems altered to ensure the problem does not reoccur:

a. DON or Designee will in-service Nursing staff on following Physicians Orders for Wound Care / Pressure Sore Reduction on October 19, 2020. (See Attachment C)
b. DON/Designee will in-service Nursing Staff on Monitoring Bowel Management Regimen on October 21, 2020. (See Attachment D)
c. DON or Designee in-service Certified Nurse Aide Regarding Appropriate Documentation of Bowel Movements and Point of Care Charting on October 21,2020. (See Attachment E)
d. Bettendorf Healthcare Center has contracted with Vohra Wound Physicians to provide in-house weekly Wound Physician Visits. Dr. Kim's initial visit was on November 18, 2020.
e. DON or Designee will begin conducting rounds with Dr. Kim on a weekly basis begin on November 18, 2020.

4. Monitoring of performance to ensure solutions are permanent:
   a. DON or designee will monitor through Point Click Care Alert Report "residents with no documented BM in last 3 days" at least twice weekly for 4 weeks then monthly to ensure Resident's Bowel Protocol and Documentation is being completed for on-going compliance. Findings will be reported monthly to QAPI (See Attachment F).
   b. DON or Designee will monitor through facility audit (5) Resident's Physician Orders & Treatment Administration Record to ensure treatments are completed & documented weekly for 6 weeks and then monthly. Findings will be reported to monthly QAPI (See Attachment G).
5. **Date of compliance: November 18, 2020**

F686 Pressure Treatment/Svcs to Prevent/Heal Pressure Ulcer

1. How the deficiency will be corrected as it related to R4:
   a. R4 returned from the hospital on November 2, 2020. R4s care plan and interventions were reviewed & updated related to pressure ulcer interventions and treatments on November 3, 2020.
   b. R4's returned from hospital on November 2, 2020 & wounds were re-evaluated by Wound Care Nurse upon readmission to the facility on November 2, 2020.
   c. Therapy assessed R4 for appropriateness of wheelchair on November 6, 2020.
   d. R4 began being following by Dr. Kim from Vohra Wound Physicians staring November 18,2020.
2. All residents have the potential to be affected by this deficient practice.
3. Measures taken or systems altered to ensure the problem does not reoccur:
   a. DON or designee completed 100% Audit of all resident's care plans to ensure their care plans had appropriate pressure ulcer prevention/ interventions in place by November 12, 2020.
   b. DON or Designee will in-service license nurses on following Physicians Orders for Wound Care / Pressure Sore Reduction on October 19, 2020 (See Attachment C).
4. Monitoring of performance to ensure solutions are permanent:
   a. DON or designee will monitor through facility audit tool (5) Resident's Treatment Administration Records to Verify treatments are completed & documented per Physician Order weekly for 6 weeks & then monthly. Monitoring findings will be reported in monthly QAPI. (See attachment G)
   b. DON or designee will monitor through facility audit tool resident's wound clinic paperwork following any appointments to ensure interventions and treatments followed as ordered. Findings will be reported monthly QAPI.
5. **Date of compliance: November 18, 2020**