STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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: 11-9-18 The following deficiencies were identified during the investigation of complaint #78879-C completed 10/11/18 through 10/23/18. Complaint #78879-C was substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B	F 000		
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. 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, staff interview and policy review the facility failed to always ensure residents remained free of development and provide treatment of pressure ulcers for 3 of 4 residents reviewed. (Resident #1, #2 & #3) The facility identified a census of 47 residents. Findings include:	F 686		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 1 1. According to the MDS dated 8/2/18 Resident #2 had diagnoses that included Alzheimer's disease, dementia. atrial fibrillation and failure to thrive. The MDS identified the resident had a BIMs score of 00 which indicated severe cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident at risk for developing pressure ulcers. The care plan with a revision date of 8/8/18 and target date of 10/29/18 directed a. CNAs (certified nursing assistant) to monitor for any skin breakdown with cares 2 times a day and as needed. b. Alert nurse of any abnormalities and nurse to alert physician. c. Treat as needed. d. Weekly skin assessment completed by nurse and document in nurse's notes. Alert physician of any anomalies and treat as needed/ordered. e. Staff to ensure resident is positioned side to side during the night. f. Ensure the resident is repositioned frequently throughout the day and night time hours. g. Monitor for skin breakdown 2 times a week and as needed with whirlpool/showers. Alert nurse of any abnormalities. h. Resident to lay own 1 hour in am and PM. Resident will refuse to lay down at times. staff to reeducate on importance of laying resident own in am/pm to prevent skin breakdown. Added to the MAR (medication administration record) to ensure good effort is made and monitor compliance daily. Review of the Braden Scale dated 8/2/18	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 2	F 686		

revealed the resident had a score of 13 which indicated moderate risk for the development of pressure areas.

Review of the Physician's order dated 7/24/18 revealed the nurse observed an area on the left buttock between the upper thigh and buttock, area measures 2 cm by 0.3 cm excoriation with bloody drainage. The area cleansed and barrier applied. An area also observed on the right inner buttock pink, reddened, excoriation and without drainage. The area measured 3.5 cm by 1.3 cm. Area cleansed and skin barrier applied. The new order included Exuderm dressing bandage every 3 days and as needed.

Review of the Physician's order dated 8/20/18 revealed the resident had areas to the bilateral buttocks and included tan order for a wound consult.

Review of the Physician's order dated 8/27/18 revealed the following orders:
a. right buttock apply medihoney and foam dressing 3 times a week and as needed for saturation.
b. Left buttock cover with foam dressing to be changed 3 times a week and as needed for saturation.
c. Continue preventative measures, air mattress, cushions to chair, lie down to rest in AM and PM.
d. Nutritional supplement to be given 2 times a day or nutritional consult recommended.

Review of the Physician's order dated 8/27/18 revealed the order for medpass 2.0 to be given 2 times a day.

Review of the Physician's Process Notes dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 3 9/17/18 revealed the following orders: a. Discontinue wound care to the right buttock. b. Change left side dressing to venelix and gauze 2 times a day and as needed for saturation for 7 days, then report. c. Implement calmoseptine to areas not under gauze. Review of the Physician's Progress Notes dated 10/2/18 revealed the following orders: a. Discontinue gauze and tape. b. Continue with venelex covered with optifoam gentle. c. New cushion to wheelchair; maybe try waffle. d. New air mattress or have current one checked to ensure working properly. Review of the Physician's fax dated 10/14/18 revealed the resident in substantial pain due to the wound. When up for meals and sitting on her left buttock. She is wincing and writhing and won't eat half the time due to pain. Order received for Tramadol (analgesic) 50 mg (milligram) every 6 hour as needed for pain. Review of the Wound Care Nurse notes revealed the following assessments: a. 8/27/18 Left buttock, wound appears to be a healed pressure ulcer pink and intact. Right gluteal region 1.5 cm by 2 cm by 0.1 cm, 75% yellow slough and 25 % pink epithealialized tissue present. The edges attached and surrounding tissue intact. b. 9/17/18 Right ischial wound intact and pink, Left ischial area declined 3.5 cm by 3.5 cm, yellow with brown center and moist to touch. The surrounding tissue intact.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 4 c. 10/2/18 Left ischium wound measures 2.9 cm by 3 cm by 0.5 cm open moist and yellow. Edges attached and surrounding skin intact. When exam initiated resident saturated with urine and her dressings were saturated as well. d. 10/16/18 Left ischium. Wound measures 3.5 cm by 3.7 cm by 2.5 cm. The wound open, wet and all necrotic tissue. The surrounding skin remains intact. Feel the wound tunnels down further to 2.5 cm and a possibility of a probing to the bone but due to the pain the resident requests the exam stop. The document identified the pressure ulcer had greatly deteriorated since last seen and the wound care nurse had not been contacted sooner. Unfortunately we are at a place that needs further intervention if progressive treatment warranted. Surgical intervention probably what will have to be sought next. The resident could be treated in the facility as best as can using topical remedies, could be seen through the emergency room and admitted to the hospital for surgical consult and intervention which would then probably require IV antibiotics,, surgical procedures and possible wound VAC or could possibly even look into something like hospice care if there wishes just to keep her comfortable and pain-free at the present time pain one of the biggest issues with the wounds in regards to the resident's overall status. After long discussion with family she feels they should start with the basics of getting some lab work completed. Review of the Progress Notes dated 7/24/18 at 9:12 revealed the CNA reported and open area. The nurse observed the left buttock, between the upper thigh and buttock a 2 cm by 0.3 cm	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 5 excoriation with bloody drainage. The nurse cleansed the area and applied barrier. The nurse also observed the right inner buttock a pink reddened excoriation without drainage. The area measured 3.5 cm by 1.3 cm. The area cleansed and skin barrier applied. Review of the Non-Pressure Weekly Skin Record revealed the resident had an area to the left lower buttock first observed 7/27/18. The following assessments recorded of the area: a. 8/16/18, the area had scant, serous exudate and measured 3.3 cm by 3.5 cm by 0 cm. The wound had no odor, had granulation tissue and normal surrounding skin. b. 8/23/18, the area measured 3.5 cm by 3.5 cm by 0 cm. The wound had no odor, had epithelial tissue and normal surrounding skin. c. 8/30/18 the area measured 3 cm by 3 cm by 0 cm. The wound had no odor, had epithelial tissue and normal surrounding skin. d. 9/10/18 the area measures 2.5 cm by 3 cm width. The wound with odor, and wound bed with epithelial tissue, surrounding tissue normal. Improving. e. 9/19/18 the area measured 2.5 cm by 3 cm by 0 cm. The wound had no odor, had epithelial tissue and normal surrounding skin. f. 9/17/18 the wound measured 3 cm by 4 cm by 0 cm. The wound had no odor, had granulation tissue and excoriated surrounding skin. g. 9/24/18 the area measured 3 cm by 2.5 cm by 0 cm. Review of the Pressure Injury Weekly Assessment dated 9/19/18 revealed the area identified a pressure area. The area had the following measurements: and measured a, 9/19/18, 3 cm by 4 cm by 0 cm and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 6 unstageable. The wound bed had black tissue in the center and yellow surrounding. b. 10/15/18, 2.8 cm by 3.8 cm by 2.5 cm and unstageable. The wound had a large amount of purulent drainage and slight foul odor present on the dressing. The wound bed had 100% slough tissue. The surrounding tissue purple in color and edges rolled. Review of the TAR (treatment administration record) September 1, 2018 through 9/30 18 revealed the following: a. Left side buttock apply venelex ointment, cover with gauze 2 times a day and as needed for saturation for 7 days then report. The treatment not documented administered on 9/23/18 at hour of sleep. b. Effective 9/18/18: Left side buttock apply venelex ointment, cover with gauze 2 times a day and as needed saturation for 7 days. Treatment not documented administered. Review of the TAR dated 10/1/18 through 10/31/18 revealed the following treatments: a. Effective 10/4/18: Cleanse wound. Apply venelex ointment to left buttock wound, cover with optifoam gentel 2 times a day and as needed for soilage. The treatment not documented completed on 10/4/18 AM or 10/8/18 on the AM or PM treatments. b. Left side buttock apply venelex ointment, cover with gauze 2 times a day and as needed saturation for 7 days. No treatments documented from 10/1/18 through 10/4/18. Observation on 10/17/18 at 10:30 AM revealed Staff A, LPN (licensed practical nurse) provided	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 7 would care to the resident's Left buttock with area 3 cm by 4 cm open area. Depth not measured and identified by Staff A packing placed by wound nurse and to remain. Staff A also identified the wound infected. Wound cleansed with Hysept 0.25% Venelex ointment to wound base and new dressing applied. During an interview with Staff A, LPN on 10/17/18 at 3:15 PM she stated the resident's wound inside had been bright red and beefy. A few days later it had been black and a few weeks later had been pussy looking. The wound looks like it's closing a bit now. She stated she noticed it getting worse and she kept educating staff to reposition her. She further stated all CNAs are getting it now and she has not seen the resident on her back since this week and she had been positioned on her sides. During an interview with the Wound Nurse on 10/18/18 at 1:50 PM she stated she 1st saw Resident #2 the end of August. At that time the wound was 1.5 cm by 2 cm by 0.1 cm, was yellow but had some epithelial tissue. Staff tried Aquacel and foam dressing. The switched to venelex and on the 18 th of September it had gotten bigger. She stated she tried to be at the facility every other week. The area almost doubled in size and she had not been contacted. She ordered a foley catheter due to incontinence and worsened ulcer. She went back in 2 weeks and the area looked better. She continued venelex and the wound had no depth and no tunneling. She suggested a new mattress or have the supplier check it and have a new cushion. She stated she was told there was a new one. Staff were to contact her if the wound worsened. Now it is open, necrotic and has tunneling. She did measure 2.5 cm depth and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 8 probably could have gotten more and suspects it's to the bone, but had to stop due to pain. She went over treatment options with family and had not heard back any decisions at this time. She further stated she definitely expected the facility to notify her when there had been a change. She stated she also noted Tramadol was ordered for pain in the wound which also indicted a change. 2. According to the MDS dated 8/2/18 Resident #3 had diagnoses that included atrial fibrillation, coronary artery disease, diabetes mellitus, arthritis, cerebrovascular accident, multiple sclerosis and depression. The MDS identified the resident had a BIMs score of 15 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers, ambulation, dressing and toilet use. The MDS identified the resident at risk of developing pressure ulcers. The care plan identified potential alteration in kin integrity related to decreased mobility, diabetes, MS, and occasional urinary incontinence. initiated 1/14/16 and revised on 6/14/18 directed staff to: a. Monitor for skin breakdown with baths 2 times weekly and as needed. b. Monitor for skin breakdown while providing cares 2 times a days and as needed and notify the nurse of any anomalies and alert the physician. c. Provide treatment to heel/ankle per physician orders and weekly skin assessment completed by RN/LPN and notify the physician of any abnormalities and treat as ordered/needed. Review of the Braden Scale dated 8/29/18 revealed the resident had a score of 15 which indicated a low risk for developing pressure	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 9 ulcers. Review of the MD (Medical Doctor)/Nursing Communications dated 7/26/18 revealed the resident noted to have excoriated area measuring 0.3 cm by 0.3 cm to the right inner mid buttock. The resident stated she did not know it had been there but had excoriated areas on her buttock in the past. The area measured and calmoseptine applied. Review of the Discharge Instructions dated 8//12/18 revealed the resident fitted with a boot and to follow up with orthopedics. Orders include elevate the left lower leg and ice/cold pack applied for 20 minutes at a time every hour to 2 hours. Review of the MD/Nursing Communications dated 9/3/18 revealed staff found a new skin area to the coccyx. The area measured 0.9 cm by 0.2 cm. No drainage observed. No increased redness/inflammation surrounding the area. Skin pink/red in color. The resident continued with loose stools, skin barrier applied. New order included clean, dry and apply Mepilex till healed, change position every 2 hours and keep off the area as much as possible. Review of the FAX to the Physician dated 9/6/18 revealed the resident had a blister measuring 2.5 by 4.5 cm to her inner heal. The blister dark red and intact. Staff discontinued the heel boot related to the ankle sprain and she is currently transferring with a hoyer lift due to increased weakness. New order included consult to Physical therapy and protect with allevyn dressing until then.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 10 Review of the Consultation/Clinic Referral dated 9/11/18 revealed the following: a, Left heel and lateral malleolus-deep injury. Change dressing weekly if remains intact. b, Left calcaneus-stage 3 pressure injury: dressing change Monday, Wednesday and Friday; gentle cleanse with sterile saline or afclens. Cover with silicone foam dressing. c. Sacrum stage 3 pressure injury: dressing change Monday, Wednesday and Friday; gentle cleanse with sterile saline or safclens. Cover with silicone foam dressing and change more often if soiled or displaced. d. Nutritional consult-consider supplementation.. e. Alternating air pressure mattress, f. T-gel pressure relieving device at all times when sitting. g. Repositioning schedule. Every 30 minutes awake, every 2 hours asleep. Follow-up every 2 weeks unless condition worsens. Review of the Fax dated 9/13/18 revealed the order for Arginaid 1 packet every day for skin healing. Review of the Physician Fax dated 9/14/18 revealed the order to change coccyx and right buttock treatment with wound cleanser, pat dry, apply skin prep and cover with hydrogel wound dressing. Change every 3 days and as needed if soiled or falls off. Discontinue when healed. Review of the Doctor's Order sheet dated 9/25/18 revealed the following orders: a. Left lateral malleolus now open and tender: continue with same dressing recommendations as 9/10 except add silicone gel disc over lateral malleolus on top of allevyn gentle and hold in place with soft.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 11 b. Dressing on sacrum needs to follow dressing orders from 9/10. Dressing was also soiled underneath with feces today. c. Please obtain t-gel or inflatable Roho cushion for her chair. Review of the Consultation/Clinic Referral dated 10/2/18 revealed the resident had liquid stools today and into the sacral wound. The wound did not have a dressing on. Please follow current dressing plan and replace if soiled or displaced. Observation on 10/11/18 at 11:30 AM physical therapy wheeled resident to the dining room table. Observation revealed pressure relieving cushion in wheel chair. Observation on 10/11/18 at 1 PM resident wheeled self back to room feet resting on wheel chair pedal. During an interview with family on 10/17/18 at 3:40 PM she stated she had been to all of the resident's appointments at the wound clinic. She further stated the resident did not have placement of a dressing over her wound on one of the appointments. She had diarrhea and it did appear fecal material had coated the wound. The wound clinic had been very upset about it and she talked to the facility about the incident. 3. According to the MDS (minimum data set) dated 8/9/18 Resident #1 had diagnoses that included dementia, respiratory failure, shortness of breath, spinal stenosis and osteoporosis. The MDS identified the resident had a BIMs (brief interview of mental status) score of 5 which indicated severe cognitive impairment. According to the MDS the resident required extensive	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 12 assistance with bed mobility, transfers, dressing and toilet use. The care plan dated 8/10/18 revealed the resident had a history of an open area on the right gluteal fold on 3/16/17. The care plan directed staff to: a. Monitor for any skin breakdown with cares 2 times a day and alert the nurse/physician if any occur and treat as needed/ordered. b. Monitor for skin breakdown with cares BID (twice daily). c. Alert nurse/physician if occur and treat as needed/ordered. Review of the Braden Scale dated 8/9/18 revealed the resident had a score of 13 which indicated moderate risk for developing pressure sores. Review of the Physician's Order dated 9/24/18 revealed the resident had an area to the left sacrum that had reopened measuring 0.5 cm (centimeters) by 0.4 cm. The wound bed pink with no drainage. Orders included cleanse with wound cleanser and apply optifoam, change every other day and as needed till healed. Review of the Medical Doctor Communications note dated 10/12/18 revealed the following: Left buttock open area measured 5 cm by 7 cm, hard, indented area, dark purple/maroon in color at base with blue/purple color on outer edges, does wince in pain when assessing and cleansing area. No drainage noted, does have foul odor present and also has hard area extending up thee left butt cheek. The order included wound consult. Review of the Consultation/Clinic Referral dated	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 13 10/17/18 revealed the order for Augmentin (antibiotic) 875 mg (milligrams) 2 times a day for 14 days and wound referral. (Note the order was received 5 days after communication to the medical doctor on 10/12/18). Review of the Non-Pressure Weekly Skin Record dated 9/28/18 revealed the resident had an area on the left buttock that measured 0.5 cm by 0.4 cm by 0 cm. Review of the Weekly Skin Assessment revealed the resident had the following open areas. a. 10/5/18 - left buttock pressure area stage 2 that measured 3 cm by 2 cm and a pressure area stage 2 on the sacrum that measured 2.5 by 0.5 cm. Review of the Pressure Injury Weekly Assessment revealed the following measurements of the left buttock: a. 10/12/18 - 5 cm by 7 cm by 0 cm Open area with indentation, purple/maroon area to base, blue/red outer edges. Review of the Pressure Injury Weekly Assessment revealed the following measurements of the coccyx: a. 10/12/18 0.5 cm by 0.1 cm by 0 pink/red wound bed appearance. Observation on 10/17/18 at 3:55 PM revealed the resident had a dressing with large amount of drainage and the dressing started to become loose. The DON (Director of Nursing) removed the old dressing and a pressure area 5 cm by 3 cm with yellow slough noted to the left lower buttock. The surrounding tissue firm to touch. The DON cleansed the wound with cleanser and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 14 applied a new dressing. Review of the Provider Wound Assessment dated 10/18/18 revealed the resident ischium had a large open area that measured 3.5 cm by 5 cm by 1 cm that had black to brown in the center, yellow around the edges, wet with a moderate amount of serosanguineous drainage present. The surrounding tissue red and erythematous and very indurated and hard with retraction present. There is a small foul odor present. The resident also had a small open fink and moist pressure ulcer to her sacral region that is midline and measured 0..3 cm by 0.3 cm and the surrounding skin pink but intact. The resident verbalized some discomfort to the lower larger area. The resident required further examination by the personal care physician, Contacted the resident's physician and made hi aware of the findings and concerns. Treatment options reviewed with the family and can range from anywhere to treating at the facility by keeping the resident comfortable and managing the symptoms to surgical intervention that could be completed in the hospital setting and may be even the consideration of consulting hospice. During an interview with the wound nurse on 10/18/18 at 1:50 PM she stated she had been asked to look at the resident's wound and it had been the first time she had seen it. She called the resident's Doctor and she did feel the wound had a lot of necrotic tissue and the surrounding skin indurated. She stated she may need surgical intervention. She stated she should have been seen by a provider sooner. She further stated the facility has a lot high complex care residents and use a temp staff.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 15 Review of the Consultation/Clinic Referral dated 10/9/18 revealed all areas improving and dressings in place. Review of the Pressure Injury Weekly Assessment revealed the following measurements for the right buttock: a. 8/20/18 1 cm by 0.5 cm., red. b. 8/27/18 7 cm by 4 cm., pink and fragile. c. 8/29/18 7.2 cm by 4.8 cm., pink/red. d. 9/11/18 2 cm by 2.5 cm., open and red. e. 9/18/18 0.6 cm by 0.2 cm., Stage 2, pink. f. 9/24/28 0.1 cm by 0.2 cm., Stage 2 with 100% pink granulation. g. 10/3/18 0.1 cm by 0.1 cm Stage 2 100% pink. The non-pressure weekly skin record dated 9/14/18 identified the right buttock 1.2 cm by 1.3 cm. Review of the Pressure Injury Weekly Assessment revealed the following measurements for the left inner heel: a. 9/6/18 2.5 cm by 4.5 cm., Stage 2 blister b. 9/11/18 2.5 by 4.5 cm., Stage 2 blister c. 9/18/18 2.5 cm by 4.5 cm., unstageable, outer pink, 1.3 by 2.8 cm slough center d. 9/24/18 3.5 cm by 3.2 cm unstageable, 90% necrotic, 10% pink granulation. e. 10/3/18 2.5 cm by 3 cm unstageable, 75% white/yellow slough, 25% pink granulation f. 10/9/18 1.6 cm by 2.9 cm unstageable, 100 % pink granulated tissue. Review of the Pressure Injury Weekly Assessment revealed the following measurements for the sacrum: a. 9/11/18 2 cm by 0.5 cm open with a scab layer of white blood cells. Stage 3 b. 9/18/18 1.2 cm by 1 cm by 0.1 cm stage 2.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 16 50% pink and 50 % slough. c. 9/24/18 1 cm by 1 cm Stage 2. 50 % white slough 50 % pink granulation. d. 9/24/18 1 cm by 1 cm by 0.1 cm., Stage 2. 50% white slough, 50% pink granulation. c. 10/3/18 1 cm by 0.5 cm by 0.1 cm., unstageable. 90% slough, 10% granulation. d. 10/9/18 0.7 by 0.2 cm by 0 cm., unstagable. 100% slough. Review of the Pressure Injury Weekly Assessment revealed the following measurements for the left outer ankle: a. 9/14/18 1.7 cm by 0.8 cm., Stage 1, dark pink b. 9/18/18 1 cm by 0.6 cm., Stage 1, dark red. c. 9/24/18 1.5 cm by 1.5 cm., unstageable, cover with scab-like tissue. d. 10/3/18 1.2 cm by 1.5 cm., unstageable, 75% pink granulation, 25% slough. e. 10/9/18 1.2 cm by 0.6 cm., unstageable, pink granulation tissue. Review of the Pressure Injury Weekly Assessment revealed the following measurements for the left outer heel. a. 9/14/18 1.4 cm by 3.5 cm Stage 1, dark pink. b. 9/18/18 0.5 cm by 0.8 cm Stage 1, dark red. c. 9/24/18 0.8 cm by 0.8 cm unstageable. dark red. d. 10/3/18 0.6 cm by 0.8 cm Stage 1, red/purple. e. 10/9/18 0.3 cm by 1 cm Stage 1, (No wound bed assessment) During an interview with Staff A, LPN on 10/17/18 at 3:15 PM she stated nurses responsible for assessing skin under a boot every week. The CNAs good at reporting any changes or open areas of resident's skin.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 17 During an interview with Staff D, CNA she stated she had to take the resident's boot off to dress her and looked at her skin every day. She noticed open areas and let the nurse know. Before the areas opened, they were red. The red faded but still remained there. She further stated there have been times she went in the resident's room and she did not have dressings on. Review of the Policy and Procedure titled Skin Care and Wound Management dated 6/2015 directed staff to do the following: a. Complete the Braden Scale on admission, weekly times 4 and then quarterly to identify the resident pressure ulcer risk indicators. b. Complete the Admission Skin Sweep and the Admission Clinical Information and initial care plan on admission. Initiate the weekly skin sweep thereafter, Identify areas of skin impairment and any pre-existing signs. c. Determine the reason a resident at risk for pressure ulcer development. d. Develop a care plan with input from the interdisciplinary team and the resident and family party. Document individualized goals and interventions to manage risk factors. e. Communicate risk factors and interventions to the care giving team, resident and family party.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 692	Continued From page 18 ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to always ensure residents nutritional needs met per the dietitians recommendations for 1 of 4 residents reviewed. (Resident #2) The facility identified a census of 47 residents. Findings include: 1. According to the MDS (minimum data set) dated 8/2/18 Resident #2 had diagnoses that included Alzheimer's disease, diarrhea, atrial fibrillation, failure to thrive and history of cerebral infarction. The MDS identified the resident had a BIMs (brief interview for mental status) of 0 which indicated severe cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use and supervision with eating. The MDS identified the resident at risk for developing pressure ulcers.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 692	Continued From page 19 The care plan dated 4/13/17 directed staff to provide supervision to set up help with meal preparation/eating and identified the resident able to feed herself. The care plan directed staff to provide the diet per physician orders and she received a regular mechanical diet. Review of the Braden Scale dated 8/2/18 revealed the resident had a score of 13 which indicated a moderate risk for development of pressure sores. Review of the Progress Notes dated 9/18/18 at 9:22 AM revealed the dietitian follow up for skin healing and noted a sore to the buttocks continued and seen by the wound care nurse with treatment in place. The resident consumed a regular diet, mechanical soft foods and feeds herself with and intake of 25 to 75 %. She takes med pass 2 ounces 2 times a day and had estimated protein needs at 55 to 65 grams. She had taken 66 grams through her diet and med pass on average to meet her needs. Will trial 1 scoop Beneprotein daily to foods like mashed potatoes, soup etc. Discussed with nursing and dietary staff. Will monitor ongoing and adjust approaches as needed. Review of the Wound Care Nurse documentation dated 10/16/18 revealed the left ischium measurements of the wound 3.5 cm by 3.7 cm by 2.5 cm. The wound open, wet and all necrotic tissue. The surrounding skin remains intact. Feels the wound tunnels down further to 2.5 cm and a possibility of a probing to the bone but due to the pain the resident requests the exam stop. Review of the Dietary Type Report (not dated) revealed the resident had an order for a regular	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 692	Continued From page 20 mechanical soft diet and supplement of med pass 2.0. Observation on 10/17/18 at 7:30 AM revealed Staff G, Cook served the morning meal. At 8:03 AM she served the resident egg, toast with jelly, yogurt, coffee and milk. She failed to add Beneprotein to the meal. During an interview with Staff G, Cook on 10/17/18 at 8:10 AM she stated she did not add the Beneprotein to the resident's meal, that it was not available in the kitchen. She further stated she usually put it on the resident's eggs and was not aware it was not available. During an interview with the Dietary Manager on 10/17/18 at 8:12 AM she stated she was not aware the Beneprotein was not available in the kitchen. She further stated the dietitian instructed staff to try the Beneprotein and she had been the only resident that dietary staff responsible to provide. All other supplements provided by nursing staff. During an interview with Director of Nursing on 10/17/18 at 9:30 AM she stated she did not locate an order for the Beneprotein for the resident. She also stated staff expected to have an order for supplements before providing to the residents. Review of the Policy and Procedure titled Supplements: Medication Pass dated 10/10 directed staff to do the following: a. Verify the resident requires additional supplementation. Review recommended interventions with the interdisciplinary team. Review and revise care plan, as indicated to reflect a new intervention and goals.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 692	Continued From page 21 b. Obtain a physician's order for a medication pass supplementation based on resident needs. Include amount to be administered a frequency in the order. Appropriate supplement products may include, but are not limited to: med pass 2.0, Arginaid, house shake, protein supplementation. c. Review the new order with nursing staff. Verify supplementation order recorded on the Medication Administration Record.	F 692		

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer

1. A skin assessment was completed and documented for Residents #1, 2, and 3 by the Licensed Nurse on 10-26-18. Notifications for change of condition were completed at the time of identification as needed.

2. An audit of wound care identification and documentation was completed on 10-25-18 by the Director of Nursing. An audit of notification of change regarding wound identification and progress was completed on 10-25-18 by the Director of Nursing. Concerns identified were reported to the physician at the time of identification.

3. Nursing staff were re-educated by the Director of Nursing on or before 11-8-18 regarding the requirements to assess, prevent, treat and notify the physician of changes pertaining to the development and healing of pressure injuries.

4. An audit of wound care documentation will be completed weekly for 12 weeks to validate nursing staff continue to assess, prevent, treat and notify the physician of changes pertaining to the development and healing of pressure injuries as required. Results of these audits will be brought to the monthly QAPI meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.

5. Date of Compliance: 11-8-18

F692 Nutrition/Hydration Status Maintenance

CFR(s): 483.25(g)(1)-(3)

1. A Physician's Order was completed and documented for Resident #2 Beneprotein by Licensed Nurse on 10-26-18. Notifications from Dietician's recommendation was completed at the time of identification as needed.
2. The Dietitian recommendation sheet identification and documentation was completed on 10/25/2018. An audit of notification of change regarding supplement identification and progress was reviewed by Dietitian and Director of Nursing completed on 10/26/2018. Concerns identified by Dietitian and Director of Nursing were reported to the physician at the time of identification.
3. Dietary Manager and MDS Coordinator were re-educated by the Director of Nursing on or before 11-9-18 regarding residents' nutritional needs, diets, hydration and health per Dietitians recommendations for Resident #2.
4. An audit of dietitian recommendation will be completed weekly for 12 weeks to validate dietary, MDS, and nursing staff continue to ensure residents nutritional needs, diet, and hydration and notify the physician of changes pertaining to ensure the residents nutritional needs met as required. Results of these audits will be brought to the monthly QAPI meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
5. Date of Compliance: 11-9-2018.