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	165466	A. BUILDING _____ B. WING _____	C 07/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 000	INITIAL COMMENTS Correction date _____ The following deficiency relates to the investigation of complaints #90368-C and #91679-C. Complaint #90368-C was not substantiated. Complaint #91679-C was substantiated. In addition, a COVID-19 Focused Infection Control Survey was conducted on July 8 - 20, 2020. The facility was found to be in compliance with the practices recommended by CMS and the Centers for Disease Control and Prevention (CDC) to prepare for COVID-19 and for the COVID-19 component of the survey. The Covid-19 survey and complaint investigation was conducted on July 8 - 20, 2020. Total residents: 68 See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	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	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/05/2020

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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promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review, and family and staff interviews, it was determined the facility failed to conduct a comprehensive assessment of a resident's wounds when she returned from the hospital, failed to provide care and services consistent with professional standards to promote wound healing and prevent infection, and failed to demonstrate the subsequent pressure ulcer deterioration was unavoidable for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 68 residents.

Findings include:

The Admission Minimum Data Set (MDS) assessment tool dated 3/6/20, revealed Resident #1 admitted to the facility on 3/1/20 with a diagnosis of atrial fibrillation, osteoporosis, peripheral venous insufficiency, chronic pain, colostomy, and intervertebral disc degeneration. The MDS revealed the resident displayed modified cognitive impairment and required extensive assist of 1 staff for bed mobility and dressing and extensive assist of 2 staff for transfers and toilet use. The MDS documented the resident had no pressure ulcers, but had 4 venous ulcers. The MDS identified Resident #1 as at risk of developing pressure ulcers.

The resident's Care Plan initiated on admission (March 2020) directed staff to assess and document the appearance of any wounds at least weekly and as needed.

The Progress Note dated 4/3/20 at 5:56 PM

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revealed she returned from an appointment with order for a wound vacuum (vac), which had been applied by the wound nurse.

The Discharge Instructions from the hospital dated 4/3/20 revealed the resident had open areas to her right calf that had been debrided with a wound vac placed. The instruction also contained a referral to a wound care physician for follow up.

The Wound Assessment from the wound care clinic dated 4/6/20 documented a Stage IV pressure ulcer on the right lower extremity that measured 5.5 cm by 3.5 cm, with a depth of 0.7 cm.

The Physician Progress Note dated 4/6/20 documented no worsening discomfort or symptoms of infection with regard to the right leg wound. The note described the area as in the process of healing with the wound vac in place.

The Skin and Wound Evaluation from the facility dated 4/10/20 revealed resident's right lateral calf measured 4.3 cm in length by 2.6 cm in width with 90 percent granulation and 10 percent slough. It revealed the wound had been debrided at an outpatient procedure last week and showed no signs of infection with a wound vac placed.

The Progress Note dated 4/13/20 at 3:44 PM revealed the resident was sent to the hospital from the wound care appointment for sepsis and a wound infection.

The History and Physical from the hospital dated 4/21/20 revealed Resident #1 presented to the hospital due to increased right lower extremity

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pain and a chronic right lower extremity ulcer. An arterial Doppler revealed right popliteal artery occlusion. The H & P documented she previously had the ulcer debrided on 4/3/20 and had been started on an antibiotic for a wound infection related to cultures that grew staph, diptheroids, and proteus.

The Progress Note from the hospital dated 5/10/20 documented the wound as improving with Resident #1's pain controlled.

The Adult Assessment and Intervention from the hospital dated 5/15/20 revealed the wound to Resident #1's right lower extremity measured 8 cm in length by 7 cm in width, with light exudate and eschar tissue present.

The Transfer Discharge Active orders dated 5/15/20 from the hospital revealed active wound orders that included:

a. Turn side to side
b. Assess pressure points on heels every shift
c. Float heels
d. Ace wrap daily around wound vac to help with edema, keep tubing on outside of ace to prevent pressure injury
e. No weight bearing
f. Wound vac cares every Monday, Wednesday and Friday to right lower heel. Veraflo cleanse dressing to run at continuous pressure 125 mmHg
g. Rooke boot to right extremity continuously
h. Prevalon boots to have on when in bed
i. Sacral Mepilex

Resident #1's Face Sheet revealed she readmitted to the facility on 5/15/20 with a

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principal diagnosis of unstageable pressure ulcer, right ankle.

The Braden Form dated 5/15/20 revealed a score of 15 and documented the resident as at risk for pressure related breakdown.

The Admission Screener dated 5/15/20 revealed Resident #1 had pressure ulcers and wounds to bilateral feet, but the form did not contain any assessments related to wound measurements.

The Progress Notes dated 5/15/20 at 1:20 PM documented the resident readmitted from the hospital with impaired skin integrity but did not include any wound assessments or measurements.

During an interview with Staff B on 7/13/20 at 2:25 PM, she verified she had completed the admission for Resident #1. Staff B reported the resident arrived at the facility with a KCI dressing which was not compatible with any of the wound vacs at the facility. She added the infection control nurse ultimately brought the wound vac, but she could not recall when or if she (Staff B) hooked it up at that time. She did remember changing the dressing so it would be compatible with the Cardinal wound vacs that the facility used.

The facility's Wound Assessment Policy dated 1/14/14 directed staff that assessing the resident for any wounds begins at the time of admission and is to be done weekly for all residents by licensed staff.

Review of the clinical record revealed it failed to contain any documentation regarding a skin

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assessment completed upon the resident's admission on 5/15/20.

During an interview with the Infection Control Nurse on 7/13/20 at 3:05 PM, she stated she remembered ordering the wound vac and all the supplies from Cardinal because the machine required by Resident #1 was different and required irrigation. She stated the specific irrigation the hospital had ordered did not work with the facility vac, so it all had to be changed. She stated she remembered ordering it all but does not remember specifically when she took it to the unit where Resident #1 resided.

The Treatment Administration Record for May 2020 revealed staff had not signed that the wound vac ran continuously until 5/15/20 at 9:00 PM.

During an interview with the resident's daughter on 7/13/20 at 2:55 PM, she reported she had spoken with her mother the day she returned from the hospital to see how she was doing. She stated Resident #1 told her the wound vac was not hooked up and running and asked her daughter if she needed to hook it up. She stated that Resident #1 told her the wound vac was in her room leaning against the wall in the corner. The daughter stated that according to her call log on her phone, she had called the facility at 7:39 PM and spoke to the night charge nurse. She remembered she had asked him if the wound vac had been hooked up and the nurse stated he hadn't gotten to it yet. The daughter stated it concerned her because although her mother had been doing well at the hospital, she developed an infection within a couple days and stated complaining of more pain.

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The Progress Note dated 5/16/20 at 1:20 AM documented staff applied the wound vac to her right lower extremity with suction at 1:25 AM.

During an interview with Staff A on 7/9/20 at 2:40 PM, he stated it was probably about 9 pm on 5/15/20 when he started Resident #1's wound vac. He reported he charted that he turned it on later because at that time he had been "playing catch up" with his documentation. He stated residents come from the hospital without their wound vac hooked up because they typically use the facility's wound vac. Staff A reported he had hooked up the machine, but did not change the dressing because it was already in place.

The Cardinal Health Clinician User Manual contained safety tips that directed the catalyst should be operated at least 22 hours out of every 24 hour period and if therapy is terminated or the vac is off for more than two hours in a 24 hour period, the dressing should be removed

During a second interview with Staff A on 7/14/20 at 9:10 AM, he stated he did not know why the wound vac was not hooked up earlier on day shift except for the possibility that they might have had to wait for another one to be delivered. He stated transfers from the hospital never go smoothly and added he did not remember where the wound vac was when he went to get it and hook it up, but he did remember hooking it up at 9 pm since that is when he signed it. He stated that when he gets to work at 6 pm he has to start medication and insulin pass so any wound care is going to occur later.

During an interview with the Wound Care Clinic

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Nurse on 7/13/20 at 2:50 PM, he stated he was returning the call for the wound care physician. He reported the wound vac could not be unhooked, not in in operation, or alarming for more than 2 hours. He stated with the dressing in place and the wound vac not hooked up for more than 2 hours, the resident's risk for a wound infection increased.

The Progress Notes dated 5/18/20 at 11:14 AM, revealed the wound vac dressing to the right lower extremity was removed with immediate odor, maceration, and a lot of fluid present. The wound vac was unable to be replaced due to maceration of the skin so staff applied a wet to dry dressing. A note at 7:22 PM documented the Nurse Practitioner had been in the facility, saw the resident, and wrote new orders to discontinue wound irrigation, hold the wound vac until 5/25/20, begin wet to dry dressings daily, culture the wound, and start the resident on Keflex.

The Progress Notes dated 5/19/20 at 1:23 AM revealed the wound to the right lower extremity emitted a foul odor, displayed maceration, and drained a moderate to large amount. At 3:06 PM, staff obtained wound cultures and at 4:43 PM, the wound to the right lower extremity had deteriorated from the last assessment.

The Skin and Wound Evaluation form dated 5/19/20 revealed the wound to the resident's right lateral calf measured 12.5 cm by 6.2 cm in width with 80 percent slough present, increased green drainage, increased pain rated at 9/10, and a moderate odor noted after cleansing. The note described the wound as deteriorating with denuded and macerated surrounding tissue.

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F 686	Continued From page 8 The Microbiology Report from the resident's right extremity wound culture dated 5/19/20 revealed many pseudomonas and proteus species present with a new order for Doxycycline. During an interview with the Director of Nursing on 7/16/20 at 12:20 PM, she stated that she was aware the wound vac was not started until the night nurse initiated it at 9 pm. She stated that she expected it to be started earlier by the admitting nurse when she changed the dressing, but did not know why it wasn't.	F 686		