STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165217	A. BUILDING _____ B. WING _____	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS Correction date: 3-26-21 The Iowa Department of Inspections and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C conducted this Investigation. The facility was found to be NOT IN COMPLIANCE. Total residents: 30 Onsite dates: 3/15/21 - 3/25/21 Complaint #'s reviewed: #94627-C not substantiated. #96382-C substantiated. #96441-C substantiated.	F 000	This constitutes my credible allegation of compliance. All deficiencies will be corrected by March 26, 2021. This plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely because the provisions of Federal and/or State law require it.	
F 684 SS=D	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 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 clinical record review, staff and resident	F 684	F 684 The nursing department failed to ensure that 5 of 30 resident's baths were not documented in the Point Click Care technology program. All nursing staff were educated on utilizing PCC and not paper to document the refusal or completion of resident baths. Resident #2, #3, #5, #6, and #7 desires with bathing has been (continued on next page)	

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

4-22-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165217	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 684	Continued From page 1 interviews the facility failed to provide needed care and services that are resident centered, in accordance with resident preferences, by failing to provide baths for 5 of 7 residents reviewed (#2, 3, 5, 6 and 7). The facility reported a census of 30 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool dated 2/3/21 Resident #2 had diagnoses that included chronic kidney disease stage 3, hypertension, diabetes, Alzheimer's disease, and atherosclerotic heart disease. The MDS documented the resident was severely impaired for cognitive skills. The MDS also documented she required extensive assist of 2 staff for bed mobility, transfers, ambulation, dressing, hygiene and toileting. The Care Plan dated 11/5/20 for Resident #2 indicated she has an activity of daily living (ADL) self-care deficit related to dementia and listed an intervention for bathing/showering: avoid scrubbing and pat dry sensitive skin. The care plan lacked any interventions for frequency of bathing. The Showers Report revealed Resident #2 did not have a bath or shower the week of 2/7/21 and went 13 days without a bath or shower. During an interview with the ADON on 3/24/21 at 2:40 PM, She stated that the facility expects all residents to receive a bath twice per week and if they refuse they are to be approached and offered one the next day. During an interview with the Administrator on	F 684	updated on his/her care plan. The Care Plan coordinator to review resident bathing care plans and update as needed in the next assessment period. The Admin. nurses have and will continue to randomly audit resident bathing compliance thru PCC and will report any negative findings to the daily Quality Assurance team for further address as needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 2 3/24/21 at 4:38 PM she stated there is a part time aide that thought she was supposed to document on every ADL task so that is why 97 for not applicable is all that is charted. 2. According to the quarterly Minimum Data Set (MDS) assessment tool dated 1/20/21 Resident #3 had diagnoses that included atrial fibrillation, hypertension, renal insufficiency, neurogenic bladder, diabetes, Alzheimer's disease and vascular dementia. The MDS documented the resident was severely impaired for cognitive skills. The MDS also documented he required extensive assist of 2 staff for bed mobility, transfers, ambulation, dressing, hygiene, toileting and total dependence for bathing. The Care Plan dated 10/13/17 documented Resident #3 had altered ADL's related to dementia. It listed interventions for one staff to assist with his bath as needed but lacked frequency of how often to give a bath or shower. The Showers Report revealed Resident #3 did not have a bath the week of 1/24/21 and 2/7/21 and went 12 days with no bath or shower the weeks of 2/22/21 to 3/5/21. 3. According to the quarterly Minimum Data Set (MDS) assessment tool dated 2/23/21 Resident #5 had diagnoses that included schizophrenia, anemia, asthma and congestive heart failure. The MDS documented the resident scored 14/15 for his Brief Interview of Mental Status indicating he is cognitively intact. The MDS also documented he required physical assist with his bath and was occasionally incontinent of bladder. The Care Plan dated 8/17/20 documented	F 684		

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F 684	Continued From page 3	F 684		

Resident #5 had an ADL self-care deficit related to weakness. It listed interventions for one staff to assist with his bath but lacked frequency of how often to give a bath or shower.

The Showers Report revealed Resident #5 did not get a bath or shower the weeks of 1/3/21, 1/24/21, 2/1-2/20/21 and for the week of 2/28/21.

4. According to the quarterly Minimum Data Set (MDS) assessment tool dated 1/5/21 Resident #6 had diagnoses that included chronic respiratory failure, hypertension, peripheral vascular disease, diabetes and pulmonary fibrosis. The MDS documented the resident scored 15/15 for his Brief Interview of Mental Status indicating he is cognitively intact. The MDS also documented he required extensive assist of 1 staff for transfers, dressing, toileting and bathing and was occasionally incontinent of bladder.

The Care Plan dated 10/4/19 documented Resident #6 has an ADL self-care deficit and listed an intervention that the resident required assistance with his bathing and transfers to the shower chair but lacked frequency of how often to give a bath or shower.

The Showers Report revealed Resident #6 only had bed baths from 2/1-2/10/21 and went 9 days without a bath 2/16-2/24/21. He only had 2 baths the month of February. The remaining were bed baths.

During an interview on 3/17/21 at 1:20 PM with Resident #6 he stated he has not been getting a bath every week. He added that sometimes it is because it is not a convenient time for him so they tell him they will be back but never do.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 4 5. According to the quarterly Minimum Data Set (MDS) assessment tool dated 2/25/21 Resident #7 had diagnoses that included cerebrovascular disease, hypertension, diabetes, hemiplegia, and seizure disorder. The MDS documented the resident scored 9/15 for her Brief Interview of Mental Status indicating she is cognitively intact. The MDS also documented she required extensive assist of 2 staff for transfers, dressing, toileting and bathing and was always incontinent of bladder. The Care Plan dated 3/3/21 documented Resident #7 has an ADL self-care deficit related to hemiplegia and listed an intervention that the resident required assistance with her bathing but lacked frequency of how often to give a bath or shower. The Showers Report revealed Resident #7 went 9 days between baths 1/19-1/29/21 and 8 days between baths 2/17-2/26/21. During an interview on 3/17/21 at 2:40 PM, Resident #7 and her husband stated that for the most part she is getting her baths but once in a while she will go a week without a bath.	F 684		
F 686 SS=J	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	F 686	See Next Page for Plan of Correction	

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F 686	Continued From page 5 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 observations, clinical record review, facility record review, hospital record review, staff interviews, physician interviews and hospital staff interviews the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and also failed to ensure residents with pressure ulcers received necessary treatment and services to promote healing for 3 of 3 residents reviewed (#1, 2 and 3). The facility did not demonstrate the pressure ulcer deterioration was unavoidable due to failure to provide weekly comprehensive skin assessments, care plan interventions, pressure relief, turning and repositioning. The facility reported a census of 30 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.	F 686	F 686 Based on Surveyor observation the facility failed to ensure that appropriate pressure ulcer management was provided in 3 residents of a census of 30. Resident #1 was discharged. Resident #2, #3 and all other residents received a comprehensive assessment on his/her skin on 03-18-2021. Although the facility thoroughly corrected the IJ on 03-18-2021 in an ongoing commitment to Quality care and written response to the deficiency statement; the following will continue to be implemented: The HSS will weekly review all skin issues and/or areas to ensure completion and compliance and make recommendations to the team for further address. New admissions will have an initial skin assessment upon admission and weekly thereafter thru the MDS assessment period. The new ADON/MDS Coordinator has updated resident individual care plans to include interventions the (con't next page)	

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F 686	Continued From page 6 Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: Inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1.According to the admission Minimum Data Set (MDS) assessment tool dated 2/25/21 Resident #1 admitted to the facility on 2/18/21 and had	F 686	(con't from prior page) facility is using for the residents individual Care plan. Care plans will be updated prn. All nursing staff have been educated on skin protocols and pressure areas on 03-18-2021. The routine annual In-service schedule was changed to include another training on pressure ulcer detection, reporting and management of care for the nursing staff on 04-16-2021. The QA committee form has been updated to include reporting new skin issues and will be addressed during the a.m. meeting. Random Admin. nurse review of pressure relieving devices shall occur and findings given to the new Admin. for further address as needed. The Quarterly QA meeting shall address any ongoing concerns with the team to ensure ongoing compliance or implantation of new interventions.	

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F 686	Continued From page 7	F 686		

diagnoses that included cerebral infarction, hemiplegia, hypertension, arthritis, gout, and obstructive sleep apnea. The MDS documented the resident scored 9/15 on the Brief Interview for Mental Status (BIMS) test, which indicated the resident was moderately impaired for cognition. The MDS also documented he required extensive assist of 2 staff for bed mobility, transfers, dressing, hygiene and toileting and was totally dependent on 2 staff for a bath. The MDS documented Resident #1 did not have any pressure ulcers but was at risk for developing pressure ulcers.

The Baseline Care Plan dated 2/18/21 documented Resident #1's skin was intact with no interventions listed for pressure ulcers or skin.

The Care Plan dated 2/25/21 documented Resident #1 was at risk for pressure ulcers related to immobility. It documented the resident required a skin inspection weekly to observe for redness, open areas, scratches, cuts, and bruises. The care plan lacked any interventions for pressure relief devices until 3/10/21 and lacked any updated interventions after skin impairment found.

The Admission Nursing Assessment dated 2/18/21 documented Resident #1 had pink intact skin.

The Braden Scale for Predicting Pressure Sore Risk dated 3/1/21 scored Resident #1 at a moderate risk for developing pressure ulcers.

The Progress Notes for Resident #1 included:
On 2/18/21 at 5:44 PM staff documented that, he admitted to the facility, had 2+ edema to his feet,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 8 a bunion to his left outer foot and left sided weakness. On 2/19/21 at 9:43 AM, staff documented the resident up in his electric wheelchair, alert and oriented times three, friendly and cooperative. On 2/19/21 at 7:30 PM staff documented, the resident had moderate non-pitting edema to his bilateral lower extremities. The resident requested the nurse to look at his left foot. Callous on bunion left foot is red, 2 small scabs left great toe 0.2cm each. The physician and family were notified. On 2/25/21 at 5:30 AM staff, documented area to left inner buttock superficial shearing 2cmx1cm also noted area right inner buttocks superficial skin loss shear area 1cmx0.2cm. Areas cleansed and treatment applied. Physician notified via fax and family notified. (Skin assessment done on 2/25/21 for these areas only) On 2/25/21 at 10:00 PM, staff documented an area to his left elbow measured 0.5cm circular abrasion. Treatment applied and physician and family notified. On 2/27/21 at 2:23 PM staff documented that, a fax from the physician was received with new orders for his left foot and left elbow. TAR updated and family notified. On 3/3/21 at 10:57 AM, staff documented no new skin areas noted. On 3/6/21 at 9:00 PM staff documented the resident was having increased confusion and not knowing where his wife is. Physician was updated. On 3/7/21 at 9:27 PM staff documented the resident was dozing off and on with increased lethargy, not able to feed self or propel self in his wheelchair. On 3/7/21 at 10:24 PM staff documented abrasions to left, elbow dry and scabbed. Scab	F 686		

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F 686	Continued From page 9 left great toe healed. Callous bunion left foot now sunken in. Physician updated via fax. On 3/8/21 at 5:45 AM, staff documented area right inner buttock healing and smaller but area to left inner buttock much worse and larger now measuring 10cmx4cm with green malodorous exudate. Physician notified via fax. (Skin assessment done on 3/8/21 for these areas only) On 3/9/21 at 1:09 PM, staff documented resident complaining of pain on his bottom. Only eating 25 percent of his meals. Treatment to bottom done. Physician updated with new orders for wound nurse consult. On 3/9/21 at 9:14 PM staff, documented resident confused and in bed all shift. On 3/10/21 at 11:32 AM staff documented resident sent to the hospital for evaluation due to lungs congested and oxygen saturation 78 percent. The Non-Pressure Skin Condition Report for the left foot callous documented: On 2/19/21 as a reddened callous on the bunion of his left foot. On 2/26/21, area continuous, has had for a while. On 3/7/21, callous remains dry is now sunken in with no exudate, erythema or increased warmth. The Non-Pressure Skin Condition Report for the left inner buttock documented: On 2/25/21, area presents as superficial shear 2cm by 1cm with light serous drainage and no odor. On 3/8/21, area much worse and larger with green malodorous exudate 10cm by 4cm with 2mm depth. On 3/9/21 coccyx is open with maceration noted throughout area pink in color, resident complaining of pain to area. Darkened and white	F 686		

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F 686	Continued From page 10 center and maceration of surrounding tissue. On 3/10/21, area to center of coccyx is now open with slough and odor. Area continues to be painful. The clinical record lacked documentation of a comprehensive skin assessment for the week of 2/28/21 for the left foot and left inner buttock. The ADL Lookback Report dated 2/18/21 to 3/10/21 revealed Resident #1 had not been turned every 2 hours. The facility policy Wound Definitions dated 9/18/12 documented to measure pressure ulcers upon identification and then weekly and to measure shearing upon identification and then weekly. The facility policy Prevention and Treatment of Pressure Ulcers dated 9/18/12 documented: 1. Purpose: To ensure a resident who enters the facility without a pressure ulcer does not develop a pressure ulcer unless the clinical condition demonstrates it was unavoidable. To ensure a resident who has a pressure ulcer receives the necessary treatment and services to promote healing, prevent infection and prevent additional pressure ulcers. 2. Elements: Pathway to pressure ulcer prevention and treatment. Pathway to pressure ulcer treatment. Braden scale. Weekly skin assessment for high risk and other skin problems. Weekly pressure ulcer assessment. 3. Procedure: Complete a Braden scale upon admission and then with every comprehensive and quarterly MDS assessment. Follow the steps as outlined in the Pathway to Pressure Ulcer Prevention and Treatment. Document on the Care Plan outcomes and assessments. Review findings with resident, family and staff.	F 686		

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F 686	Continued From page 11 The Emergency Department Encounter dated 3/10/21 documented Resident #1 presented with 3 unstageable pressure ulcers to his sacrum, lateral left great toe and right heel due to slough and/or eschar and/or deep tissue injury. The resident presented complaining of sacral ulcer pain. The resident was started on antibiotics for sepsis. During an interview on 3/16/21 at 11:50 AM with the Social Worker at the hospital, she stated Resident #1 passed away at the hospital this morning. He was not swallowing, was NPO, the wife decided she did not want to do TPN long term so he was started on comfort cares. She added that the wounds were about the same from when he came into the ER (emergency room) on 3/10/21 but were not improving. She stated the resident was septic when he came in and they were doing vitals every 15 minutes. He had pressure wounds to his bottom, left foot and both heels. He did improve from the sepsis but due to not being able to swallow, he continued to decline until he died this morning. During an interview on 3/16/21 at 1:15 PM with Staff A she stated she did not complete any wound care to Resident #1 the last weekend she worked 3/6/21 and 3/7/21. She stated she signed them off and then ran out of time so she asked the next nurse Staff C coming on to do the treatments. She stated that on 3/5/21 when she worked, she was training a new RN Staff B and she had her go with an aide and change the dressing to Resident #1's bottom. She added that any new skin issues are relayed to the ADON and she is to follow up on them.	F 686		

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F 686	Continued From page 12 During an interview on 3/16/21 at 1:50 PM with Staff B she stated she saw the wound to his bottom only once during rounds at 5:00 AM on Sunday 3/7/21. She stated that she did not provide the care she only held him over while Staff C provided the care. She added that Staff C commented on how it was much worse so Staff C was going to fax the doctor. During an interview on 3/16/21 at 2:15 PM with Staff LB, she stated she provided the care to Resident #1's buttock wound the morning of 3/7/21. She stated she notified the physician because it was much worse than when she had seen it earlier in the week. During an interview on 3/16/21 at 3:15 PM with Staff D, he stated he had completed all the ordered treatments to Resident #1's wounds on 3/3 and 3/4/21 but did not do a full assessment with measurements. He could not recall any open areas or treatments to Resident #1's heels. He stated that the ADON does all the weekly skin assessments. During an interview on 3/16/21 at 3:25 PM with the Assistant Director of Nursing (ADON), she stated all residents in the building are on the same pressure reducing mattresses the facility buys from Medline. She added that the facility has not used any air mattresses on any residents in the last 1-2 months if ever. During an interview on 3/17/21 at 11:10 AM with the ADON, she stated the skin records in Resident #1's paper chart copied for the surveyor was all that he had. She stated that he had a Stage 3 pressure ulcer on his buttock sacral area when he discharged to the hospital on 3/10/21,	F 686		

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	165217	A. BUILDING _____ B. WING _____	C 03/25/2021

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F 686	Continued From page 13	F 686		

that she had just been made aware of the deterioration of that wound and that was the only pressure area she was aware of. She stated that she was not aware of any pressure areas on his heels. She added that when a skin assessment is done it is documented on the Skin Condition Report.

During an interview on 3/17/21 at 11:33 AM with the physician for Resident #1 he stated that he was involved with reporting the complaint to DIA. He stated that when Resident #1 was brought into the hospital on 3/10/21 the wounds he had were quite extensive and that he had developed them while at the facility within 2 weeks. He added that Resident #1 did not admit to the facility with any skin issues on 2/18/21. He stated that after about a week the facility notified him that Resident #1 had a wound on his bottom but they did not report any deterioration of the wound until 3 days before hospitalization. He stated that he had been notified of some scab areas on his left foot but had never been notified of any areas on the heels. The physician stated that these areas could have all been avoided if the facility had been turning Resident #1 and if they would have provided more pressure relief devices then what they were using. He stated Resident #1 was admitted to the ER on 3/10/21 with sepsis but the cultures of the wounds and lungs never grew anything. He added that Resident #1 passed away on 3/16/21 from aspiration pneumonia but that the wounds were a complicating factor.

During an interview with the ADON on 3/24/21 at 2:35 PM she stated she updates care plans within 1 to 2 days of being told about changes and that she would typically update the care plan with any new or changing wounds or pressure ulcers. She

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 14 added that she was gone during the time the wounds got worse for Resident #1 but the charge nurses are to update the care plans but don't do it. 2. According to the quarterly Minimum Data Set (MDS) assessment tool dated 2/3/21 Resident #2 had diagnoses that included chronic kidney disease stage 3, hypertension, diabetes, Alzheimer's disease, and atherosclerotic heart disease. The MDS documented the resident was severely impaired for cognitive skills. The MDS also documented she required extensive assist of 2 staff for bed mobility, transfers, ambulation, dressing, hygiene and toileting. The MDS documented Resident #2 did not have any pressure ulcers but was at risk for developing pressure ulcers. The Care Plan dated 11/15/20 documented Resident #2 was at risk for pressure ulcers related to immobility. It documented the resident required a pressure reduction mattress on her bed but lacked documentation of an updated intervention until 3/15/21. The Braden Scale for Predicting Pressure Sore Risk dated 2/14/21 scored Resident #2 at risk for developing pressure ulcers. The Non-Pressure Skin Condition Reports for Resident #2 documented: On 1/4/21 she had two areas to her left lower buttocks 1) measuring 1cm by 0.5cm and 2) measuring 1.25cm by 0.75cm. The physician was faxed for a treatment. On 1/12/21, the area was assessed as one area measuring 4.5cm by 3cm with a green center and very painful to the resident. The physician was	F 686		

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F 686	Continued From page 15 faxed for a new treatment. On 1/13/21, the area was reassessed with the center of the area measuring 1.7cm by 3cm and is now a Stage II. The clinical record lacked comprehensive skin assessments for the weeks 1/17 and 1/24/21. On 1/31/21, the area was reassessed measuring 1.5cm by 3cm. On 2/5/21, the area was reassessed measuring 1.5cm by 2.5cm with 1mm depth, wound bed closing and no pain. The clinical record lacked comprehensive skin assessments for the weeks of 2/7, 2/14, 2/21 and 2/28/21. On 3/7/21, the area was reassessed as a Stage II measuring 1.5cm by 1cm with 1mm depth. On 3/15/21, the area was reassessed as healing and measuring 1cm by 1cm. During observation of cares on 3/17/21 at 1:30 PM, observed nurse Staff E, aide Staff F and aide Staff G enter Resident #2's room. All three staff washed their hands and donned gowns and gloves. The resident verbalized understanding when they told her they needed to do a treatment to her bottom. The aides repositioned the resident onto her side and held her while the nurse completed the cares. The resident's brief was dry. Observed an open area to resident's left hip buttock area. Observed walnut size white circular area with a red open center. The nurse did not measure it but she verbally noted the red open center to be about 2x1cm. Staff E completed the treatment per orders, removed her gloves and washed her hands. The aides completed the cares with the resident. 3. According to the quarterly Minimum Data Set (MDS) assessment tool dated 1/20/21 Resident	F 686		

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F 686	Continued From page 16	F 686		

#3 had diagnoses that included atrial fibrillation, hypertension, renal insufficiency, neurogenic bladder, diabetes, Alzheimer's disease and vascular dementia. The MDS documented the resident was severely impaired for cognitive skills. The MDS also documented he required extensive assist of 2 staff for bed mobility, transfers, ambulation, dressing, hygiene, toileting and total dependence for bathing. The MDS documented Resident #3 did not have any pressure ulcers but was at risk for developing pressure ulcers.

The Care Plan dated 2/19/20 documented Resident #3 was at risk for pressure ulcers related to immobility. It documented the resident required a pressure reduction mattress on his bed and in his wheelchair.

The Braden Scale for Predicting Pressure Sore Risk dated 1/19/21 scored Resident #3 at risk for developing pressure ulcers.

The Non-Pressure Skin Condition Reports for Resident #3 documented:
On 1/2/21 and 1/3/21, he had an open abrasion on his right inner thigh measuring 3.0cm by 2.0cm
On 1/14/21, he had no open areas.
The clinical record lacked comprehensive skin assessments for the week of 1/17/21 and 1/24/21.
On 2/2/21, he had an open area on his right upper inner buttock measuring 0.5cm
On 2//9/21 it documented the area was improving and to continue to the treatment. No measurements or description found.

During an interview with the ADON on 3/15/21 at

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F 686	Continued From page 17 1:15 PM, she stated Resident #3 did not have any open wounds or pressure areas. The situation detailed above resulted in Immediate Jeopardy (IJ) for the facility. The facility was notified of the Immediate Jeopardy on 03/18/21. The facility removed the IJ situation on03/18/21. The scope and severity of the deficiency was lowered from a "J" to a "D." The facility removed the IJ by implementing the following measures: LPN completed head to toe skin assessment on all residents in the facility 03/18/21. Contacted all Nursing employee's and educated them on skin protocols and pressure areas 03/18/21 Posted to Facility Wide Bulletin education with skin assessments and reporting issues to Charge Nurses immediately. Posted "Pressure Ulcers" in the nursing enclave and at the nurse's station for further education to our Staff. Nurses have been re-educated on utilizing the Skin Condition Reports and Pathway to Pressure Ulcer Prevention and Treatment. The Quality Assurance daily tool includes Skin Issues identified on the form and will be addressed during the morning QA meetings with the QA team. Added on the admin. team calendar a task reminder to prompt skin review weekly. Admin. Nurse shall audit skin sheets weekly for accuracy and completion of weekly skin assessments, skin condition reports and report any negative findings to the Admin. Team for further address. All steps implemented on 03-18-2021	F 686		