STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165610	A. BUILDING ______ B. WING ______	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VISTA VILLAGE	2785 1ST AVENUE S ALTOONA, IA 50009

(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 11-2-21 The following deficiencies relate to the facility's annual health survey. (See 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 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident interviews, and clinical record review the facility failed to prevent the development of a pressure wound for 1 of 1 resident reviewed (Resident # 14). The resident required extensive assistance of 1 staff for dressing. When staff donned the resident's shoes and failed to adjust them properly in the back, this caused the back of the shoe to rub and apply pressure and friction on the skin over the resident's Achille's tendon and heel bone. On 8/7/21, staff identified and documented a Stage II	F 686		

✓ gm

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.

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F 686	Continued From page 1	F 686		

pressure ulcer to the resident's left heel that measured 2.5 centimeters (cm) by 1 cm by 0.3 cm. By 10/11/2021, the area had increased slough and drainage and had developed into a Stage 3 pressure sore. The facility reported a census of 33 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.

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.

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F 686	Continued From page 2	F 686		

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.

According to the Minimum Data Set assessment tool dated 10/3/21, Resident #14 had diagnoses that included: atrial fibrillation (rapid heart rate) and needs assistance with personal care. The MDS documented the resident scored 15 of 15 possible points on the Brief Interview of Mental Status (BIMS) test, which meant the resident demonstrated intact cognitive abilities. The MDS also documented the resident required extensive assist of 1 staff for dressing and had a Stage III pressure ulcer. The MDS showed facility staff provided pressure ulcer/injury care, applications of ointments/medications other than to feet, and application of dressings to feet (with or without topical medications - a pressure wound treatment to the foot).

The Care Plan (CP) dated 8/7/21 documented Resident # 14 had a Stage 3 pressure area on the left inner heel from his new shoes. The Care Plan directed staff to use a shoe horn when putting on the resident's shoes to help prevent the back of the shoe from bending down and causing

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F 686	Continued From page 3 skin problems. The CP also directed staff to administer pain medication as ordered. The Nurse's Note dated 8/7/21 documented a Stage II pressure ulcer to the resident's left heel that measured 2.5 centimeters (cm) by 1 cm, with a depth of 0.3 cm. The Wound/Skin sheet dated 8/7/21 identified a Stage II pressure ulcer to the resident's left heel that measured 2.5 centimeters (cm) by 1 cm by 0.3 cm. The Physician's Assistant note dated 08/10/21, documented the wound measured 0.8 cm by 2.5 cm and was 90 % covered in yellow slough. The note documented the resident described the wound site as tender. The note continued to reflect chronic venous insufficiency. The Physician's Assistant note dated 09/21/21, documented the wound measured 0.8 cm by 2 cm 90 % covered in yellow slough. The note documented the resident described the wound site as tender with direct pressure. The Nurses Note dated 10/11/2021 at 10:15 AM, revealed staff informed the Primary Care Provider of a weekly skin assessment due to ulcer on left heel: 2.5 cm x 1.5 CM x 0.1 cm in depth and Stage 3 due to granulation. Informed PCP that our Wound Nurse Consultant is scheduled to see Resident # 14 - No New orders at this time. The Patient Order Sheet dated 10/11/21, documented a full thickness, Stage 3 pressure area on the left heel that measured 1 cm long by 2 cm wide with undetermined depth and moderate drainage.	F 686		

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F 686	Continued From page 4 Observation on 10/13/21 07:45 AM revealed the resident's inner left Achilles area wound was approximately 1 cm x 2 cm and 0.4 cm deep, with rolled looking edges. The area appeared clean and pink in color. During an interview on 10/11/21 at 2:45 PM, Resident # 14 reported the back of his shoe folded over and rubbed on the heel area which caused the wound. In a subsequent interview on 10/13/21 at 07:43 AM, Resident # 14 reported his heel does hurt when it is touched and when air gets to it. On 10/13/21 at 07:55 AM, the MDS Coordinator/Wound Nurse, verified staff failed to put the resident's shoes on correctly and it caused the pressure wound. At 2:52 PM, the MDS nurse reported any skin area is preventable if we know it is happening. During another interview on 10/14/21 at 09:44 AM, Resident # 14 stated he lets staff know if the wound hurts. Resident # 14 continued it hurts when I bump it, and also overnight it hurts if it rubs on the cushion that staff put under my legs. He added it burns some when the nurses are doing the treatment. The resident stated the pain gets to a 3 on a 0-10 pain scale (0 = nothing, 10 = the worse pain ever). Resident # 14 revealed staff administer scheduled acetaminophen and he will get an extra one sometimes. At 09:49 AM, the resident reported it took a few days for the wound to open. He reported he kept trying to get the Certified Nurses Aids to pull the back up on the shoes because it was hurting him. The resident confirmed the back of the shoe remained folded	F 686		

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F 686	Continued From page 5 over when he had them on for a few days before the staff addressed his concerns. In an interview on 10/14/21 at 10:05 AM, Staff C CNA reported Resident #14 told them he felt something wrong in the shoe. She added she always tried to get the back of the new shoes "up" because they were stiff compared to the older shoes. On 10/14/21 at 11:59 AM, Staff B CNA, reported the only thing she knew is that he told us after we put both of the shoes on to make sure the back was up and in the right spot. During an interview 10/14/21 at 12:03 PM, the Director of Nursing (DON), confirmed the pressure ulcer developed from the resident's new shoes. The DON could not remember whether or not Resident # 14 complained about the new shoe placement on the back of his foot for a few days before the staff found the pressure ulcer. The DON verified Resident # 14 as alert, oriented, and communicated his needs. When asked, the DON replied her expectation would be that the facility does what it can to prevent pressure ulcers from developing.	F 686		

The enclosed Plan of Correction should constitute our credible allegation of compliance and we trust you will find it adequate and acceptable.

This Plan of Correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Facility as to the accuracy of the surveyors' findings nor the conclusions drawn therefrom. The Facility's submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.

In continuing compliance with **F 686** Skin Integrity and Pressure Ulcers, Prairie Vista Village will:

Correcting the deficiency as it relates to the individual:

- Plan of care for the pressure ulcer to Resident #14's heel was immediately initiated upon identification on 8/7/21. Care and treatment is revised as indicated. Resident #14 has not worn shoe to left foot since wound was identified on 8/7/21. There have been no further pressure ulcers due to new shoes identified at PVV since 8/7/21.

To protect residents in similar situations:

- On October 29, 2021 an email was sent to the families of the residents requesting they notify Prairie Vista Village when bringing in new shoes so that we can monitor wear to ensure a comfortable, safe fit to prevent blisters or skin breakdown.
- On November 1, 2021, Education began with Nursing staff who were educated by the DON/designee on identifying residents with new shoes; the importance of making sure residents' shoes are put on properly; and to notify charge nurse immediately with any identified skin breakdown or resident concerns with shoes/discomfort.

Measures Prairie Vista Village will take or systems you will alter to ensure that the problem does not recur

- Beginning November 2, 2021, the DON/designee will ensure audits are completed to identify if any residents have new shoes; if shoes are applied appropriately; if residents voice any concerns with shoes/pain and skin is intact to heels/feet. These audits will be completed daily x 2 weeks; weekly x 2 weeks; then monthly x 2 months. Once monthly audits are completed

ongoing audits will be completed for residents during their quarterly care plan assessments.

- At Care Conferences Social Services will remind families regarding bringing new shoes into the building and communicating with facility so that the shoes can be monitored
- When residents are admitting into facility they will be given specific information regarding bringing in shoes for residents and communicating this with the staff so that shoes can be monitored

Prairie Vista Village's plans to monitor performance to make sure that solutions are permanent by:

- QAPI committee will review all audits and training regarding this deficiency monthly. QAPI committee will make recommendation and change process as needed to ensure compliancy to **F-686**