

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

PRINTED: 09/04/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/28/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEWTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 SOUTH EIGHTH AVENUE EAST</b> <b>NEWTON, IA 50208</b>		
(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 ✓ ok/CP	INITIAL COMMENTS  Correction date: <u>September 9, 2024</u>  The following deficiencies resulted from investigation of Complaints # 122752-C and # 122985-C conducted August 27, 2024 to August 28, 2024.  Complaint # 122985-C was substantiated.  See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.  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 record review, staff interviews and policy review, the facility failed to accurately document pressure ulcers for 1 of 3 residents reviewed (Resident #1). During record review of this resident's skin areas, the facility didn't assess the skin when doing the daily skilled assessments. The resident was admitted to the	F 000			
F 686 SS=D		F 686			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

TITLE

*Administrator 9/9/24*

(X6) DATE

09/04/2024

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	<p>Continued From page 1</p> <p>hospital with a decubitus ulcer (a pressure sore, bedsore, or pressure ulcer, is a localized area of skin damage caused by prolonged pressure on the skin. The pressure reduces blood flow to the area, which can lead to tissue damage and death.) to the buttocks. The facility reported a census of 45 residents.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Unstageable Ulcer: inability to see the wound bed.</p> <p>Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent</p>	F 686			

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F 686	<p>Continued From page 2</p> <p>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.</p> <p>Resident #1 hospital discharge with admit date of 8/24/24 documented the resident had diagnoses of congestive heart failure, generalized weakness, osteoporosis, and hypertension. The resident was admitted for malaise and not acting himself per family</p> <p>Review of the Weekly Nursing Skin Assessment for Resident #1 on 8/23/24 documented shearing on the coccyx measuring 3 centimeters (cm) by 2 cm with a depth of 0.2 cm. The right lower leg (rear) had an abrasion measuring 18 cm by 18.5 cm with a depth of 0.1 cm. The left lower leg (rear) had an abrasion measuring 5.0 cm by 1.0 cm with a depth of 0.1 cm.</p> <p>Progress Note for Resident #1 on 8/23/24 at 16:04 PM documented the resident noted to have redness, pain, swelling and warmth to left lower leg . Call made out to no call for recommendations. Shearing is noted on the back of calves. Left side 5.0 cm x 1.0 cm x 0.1 cm Right side 18.0 cm x 18.5 cm. Left dorsal hand bruise 9.0 cm x 9.0 cm dark purple in color. Scabs noted to bilateral lower legs right side from knee down #1 1.0 cm x 0.7 cm #2 1.0 cm x</p>	F 686			

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F 686	<p>Continued From page 3</p> <p>1.0 cm #3 1.0 cm x 0.3 cm #4 0.8 cm x 0.4 cm.</p> <p>Record review for Resident #1 revealed Daily Skilled charting on 8/24/24 18:13 PM documented there are no open areas/skin issues at this time on assessment. Daily Skilled charting on 8/24/24 at 5:02 AM documented there are no open areas/skin issues at this time on assessment. Daily Skilled charting on 8/23/24 at 4:20 PM documented here are no open areas/skin issues at this time on assessment. Daily skilled charting on 8/23/24 at 2:37 AM documented here are no open areas/skin issues at this time on assessment..</p> <p>Review of the facility Progress Notes dated 8/24/24 to 8/27/24 lacked documentation that a followup was completed to obtain physician orders for the skin issues discovered on admission.</p> <p>Review of the Hospital Progress Note for Resident #1 dated 8/24/24 documented the resident came to the hospital with a stage 2 bilateral buttocks decubitus ulcers (stage 2 decubitus ulcer, also known as a pressure ulcer, is a shallow, open wound or blister that can appear on the skin. It's caused by damage to the epidermis or dermis, the skin's outer and deeper layers, respectively). An unstageable wound to both the right and left posterior lower leg/heel. Unstageable wound starting at right upper heel and extending upwards several inches with blue-green drainage. Left upper posterior heel extending upwards sever inches denuded with unstageable wound with yellow hardened wound bed. Resident on Intravenous (IV) Clindamycin for wound infection and cellulitis.</p>	F 686			

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F 686	<p>Continued From page 4</p> <p>During an interview on 8/27/24 at 1:20 PM, Staff A, Registered Nurse (RN) 1:20 PM reported on Wednesdays she does weekly skin assessment. During the week the nurses put notes in the chart if it is a new skin area or worse when they are working. The CNAs will also fill out a shower sheet that documents any skin issues noted on shower days. She reported she had some training on skin assessments and had papers she refers to for staging of pressure ulcers. She reported Resident #1 had open skin areas to his bilateral lower legs but not on the heel. She reported they did an intervention of putting the legs up on pillows but it was hard to keep them on the pillows due to twitching frequently. She was not sure why the nurses were charting he had no skin issues when he had skin concerns noted on 8/23/24.</p> <p>During an interview on 8/28/24 at 8:15 AM Staff B, RN reported on daily skilled assessment if a resident would have skin issues they would note it there because the nurse should be doing a full skin assessment. She verbalized that she physically looks at the skin when she does any skilled assessment. She reported Resident #1 did not move around much that she is aware of.</p> <p>During an interview on 8/28/24 at 8:26 AM Staff D, Certified Nursing Assistant (CNA) reported that Resident #1 would get up to the toilet otherwise never really got up much. She reported she told the nurse on the 17th of August that Resident #1's bottom was really red and close to opening up.</p> <p>During an interview on 8/28/24 at 9:13 AM Staff C, Assistant Director of Nursing (ADON) reported that if a resident on skilled care has any</p>	F 686			

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F 686	<p>Continued From page 5</p> <p>skin concerns, she would document it on the skilled assessment.. She verbalized she would document it on the bottom of the assessment. If the skin concern was new then she would send a fax out to the physician on the area. She reported Resident #1 never really moved around much that she is aware of.</p> <p>During an interview on 8/28/24 at 9:45 AM, the Director of Nursing reported she did half the skin assessment on Resident #1. She reported when she came to work on 8/23/24 the Minimum Data Set (MDS) coordinator reported Resident #1 had open areas noted on his bilateral lower legs. She did the skin assessment on them. She reported on the Daily Skilled assessments nurses should have done a full head to toe assessment that includes checking the skins. If the skin is a new area then staff should measure the skins and notify the family and physicians. They have standing orders for treatments until the physician is able to see it.</p> <p>The facility policy titled Wound Documentation Guidelines with a revised date of April 2017 documented a pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.</p>	F 686			

Plan of Correction for Newton Health Care Center-Provider #165427

Date of Investigation: August 27-28<sup>th</sup>, 2024

Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F-686 Treatment/Services to Prevent/Heal Pressure Ulcer

- The facility does accurately document pressure ulcers.
- Resident was discharged.
- Skin sweep completed on 8/29/2024 to assess all residents for wounds and new skin areas. All residents with wounds have been assessed measured and documented on 8/29/2024.
- Completed an audit of all standing orders for all residents on 9/8/2024 for wound/skin treatments to ensure standing orders are on the MAR/TAR and care plan.
- Education provided to all nursing staff on 9/6/2024 regarding notification to DON and assessment of all new skin integrity concerns.
- Education provided to nurses on 9/6/2024 related to Weekly Skin Assessments, New Skin Concerns, Skilled Nursing Assessments, Documentation including measurements and treatments completed as ordered.
- DON/ADON/Designee will audit to ensure all wound assessments are being completed and documented with measurements, treatments completed as ordered, interventions are on care plan and followed, skin assessment sheets are reviewed, and skin concerns are addressed with dietician at weekly meetings 5 times per week for 4 weeks, 3 times weekly for 2 weeks, 2 times weekly for 2 weeks and weekly for 4 months.
- Results will be discussed at the following QA Meeting for further review of continued compliance.

Responsible Party: DON/ADON/Designee

Compliance Date: 9/9/2024

Respectfully Submitted

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