STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER VALLEY LIVING AND REHAB	400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical chart review and interview the facility failed to establish and implement accurate and appropriate care plan interventions for 3 of 9 residents (#4, #7 and #2). The facility reported a census of 44 residents. Findings include: 1. A quarterly Minimum Data Set ((MDS) dated [DATE] assessed Resident #7 with a Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicating moderate cognitive deficit. The MDS indicated the resident required limited assistance with the help of one staff for transfers and ambulation, and required extensive assistance with the help of one for dressing and toileting. The resident had [DIAGNOSES REDACTED]. Observation on 7/29/20 at 3:00 p.m. revealed Resident #7 sitting in his wheel chair in his room wearing a shoe on the left foot and a gripper sock on the right foot. Across the room from the resident was a protective boot laying on the floor. Observation on 8/4/20 at 12:20 p.m. revealed Resident #7 eating lunch with the bedside table in front of him wearing a shoe on the left foot and gripper sock on the right foot. A protective boot laid on his bed. A physician's orders [REDACTED].#7 updated on 4/20/20 directed staff to apply a gripper sock to the right foot during the day and boot during the night. The care plan also directed staff to document the progress of the ulcer on his ankle weekly. In the month of June there were only two entries containing wound measurements: on 6/5/20 and 6/22/20. A nursing note dated 7/13/20 stated the wound looked well. The entry did not include measurements. The chart lacked any other skin assessments in the month of July. 2. A Minimum Data Set ((MDS) dated [DATE] revealed Resident # 4 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS indicated that the resident required the use of a Hoyer lift for transferring and the assistance of two staff with dressing bathing and toileting. A physician's orders [REDACTED].#4 was to receive nothing by mouth (NPO) and received tube feedings five times a day through a percutaneous endoscopic gastrostomy (PEG) tube. The POS indicated the resident had a sacral wound with orders to cleanse daily and treat with [MEDICATION NAME] ag (a sterile dressing with silver) for wound treatment. The POS indicated staff should cleanse the PEG tube site daily. The resident also had an order for [REDACTED]. The care plan dated 1/14/20 directed staff to assess the ulcer/skin condition when doing treatment and to document progress weekly. A review of the clinical chart revealed that during his stay at the facility from 12/30/19 through 1/24/20, just one skin assessment completed on 1/14/20. The care plan initiated on 1/14/20 lacked interventions for daily weights, frequent oral care and suctioning of secretions. 3. A physician order [REDACTED].#2 identified [DIAGNOSES REDACTED]. Her care plan included interventions for restorative services to exercise on the Omni-cycle three times a week for 15 minutes on Monday, Wednesday and Friday. This care plan intervention was last updated on 12/27/18. In an interview with the Director of Nursing (DON) on 8/6/20 at 11:55 AM she stated that the she is currently updating the care plans and she gets much of the information during the 24 hour nursing reports. She also expects that the nursing and therapy staff would let her know if/when they have any changes in the resident's goals or conditions. The DON stated that they have someone hired to be responsible for care planning. The DON indicated that after talking to therapy staff she discovered that Resident #2 was not using the Omni-Cycle three times a week and has other restorative goals that are not included on the care plan.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical chart review and interview the facility failed to provide professional standards of care by accurately documenting and transcribing admission and transfer orders for 1 of 9 residents reviewed (Resident #4). The facility reported a census of 44 residents. Findings include: According to a Minimum Data Set ((MDS) dated [DATE], Resident #4 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS indicated that the resident required the use of a Hoyer lift for transferring and the assistance of two staff with dressing, bathing and toileting. According to the physician's orders [REDACTED].#4 received nothing by mouth and had tube feedings five times a day through a percutaneous endoscopic gastrostomy (PEG) tube. The resident had a sacral wound that was to be cleansed and monitored daily. According to the medical record, Resident #4 admitted to the facility on [DATE] from(NAME)Rehabilitation Center and discharged to the hospital on [DATE] with respiratory distress. A review of the transfer records from the(NAME)Center signed by the referring physician and dated 12/30/19 revealed orders in the transfer records that did not get transferred to the residents' facility medical record. 1) [MEDICATION NAME] (anti-fungal) suspension to be given four times a day a day. The omission was discovered and entered into the electronic chart on 1/10/20. 2) Nursing order to document intake and output daily. 3) Provide oral hygiene every 2 hours 4) Obtain vital signs three times a day 5) Provide weekly wound measurements. 6) Obtain a follow up referral to wound care and ostomy specialty care 7) Therapeutic interventions for pressure relief every 30 minutes complete full tilt for 2-3 minutes when up in chair for pressure relief due to pressure sore. This intervention did not get on the care plan. In an interview on 8/4/20 at 8:48 AM, the Director of Nursing (DON) said that it was the responsibility of the patient care coordinator to enter transfer orders. The person that was in this position was terminated the end of June and since that time, the DON entered orders. She stated that the expectation is that all doctors' orders are entered as given and staff are not to pick and choose which ones to enter. In a communication with the Administrator on 8/11/20 at 4:23 PM she stated that the facility did not have any policies related to order entry upon admission.
F 0686 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, physician interview, and facility record review, the facility failed to thoroughly assess and initiate interventions for residents with pressure sores for 4 out of 4 residents reviewed for pressure sores (Resident #5, #3, #7, #4). The facility failed to assess Resident #5's blackened toe after first identifying the skin concern on 11/4/20 at time of admit, failed to notify the physician of the skin area, failed to obtain a treatment or consultation, and failed to intervene to prevent deterioration of the toes. The failure resulted in harm to the resident when on 11/9/20, the resident found to have several blackened toes that required hospitalization , amputation, and contributed to her death. This resulted in an immediate jeopardy situation for the facility. The facility reported a census of 44 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER VALLEY LIVING AND REHAB	400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) 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. The admission MDS assessment dated [DATE] for Resident #5 identified a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, transfers, dressing, and personal hygiene. The MDS documented [DIAGNOSES REDACTED]. The MDS recorded the presence of 2 stage II pressure ulcers and 2 unstageable pressure ulcers due to slough or eschar; all 4 pressure sores present upon admission to the facility. The MDS coded skin and ulcer/injury treatments that included application of dressings to the feet. The Care Area Assessment (CAA) Summary marked ADL (Activities of Daily Living) and pressure ulcer as triggered and care planning decisions made on 11/11/19. The CAA (care area assessment) Worksheets dated 11/9/19 included the following documentation: a. The resident required assist of 2 with gait belt and front wheel walker with attached right arm brace related to cast to RUE (Right Upper Extremity) following fracture to arm with multiple breaks from fall at home when the resident attempted to go to the restroom independently. The resident noted to have weakness and pain to feet related to pressure areas prior to admission. b. The resident admitted to the facility with pressure areas to the coccyx and multiple areas to left foot toes with 2 stage II areas and 2 unstageable areas related to slough tissue. Per the resident the areas present at home for a long time, she tried to heal them with home health services, she did not wear shoes, and her feet always cold because she could not turn the heat up in her house very high. Bilateral feet observed to be light purple in color; feet elevated and sock and blankets in place. The resident stated she had the area to her coccyx for a while due to incontinence and not able to get to the restroom when needed. The Discharge Return Not Anticipated (DRNA) MDS dated [DATE] identified Resident #5 admitted to the facility on [DATE] and discharged to the hospital acutely on 11/9/19. The care plan focus area initiated 11/5/19 identified impaired skin integrity related to bladder and bowel incontinence and impaired mobility. The goal included the areas to the toes and coccyx would heal without signs/symptoms of infection by target date of 11/17/19. The interventions listed: a. assess open areas/skin condition when doing treatment, documenting progress at least weekly. b. keep skin clean and dry as possible. c. monitor for signs/symptoms of infection, i.e. redness, warmth, pain, swelling, drainage, and increased temperature. d. monitor intake of meals and record. e. monitor skin condition with daily dressing and weekly bathing. f. offer and assist to restroom upon rising, before and/or after meals, and bedtime. g. peri-care (incontinence care) twice a day and as needed after incontinent episodes. h. PRD (Pressure Reduction Distribution) to bed and wheelchair. i. report any reddened or open areas. j. treatments to areas per physician order. The Care Plan Review dated 11/7/19 documented treatments done for wounds and a copy given to Resident #5's family member. The facility Discharge Summary dated 11/11/19 documented the resident with lower right leg in poor condition and some wounds on sacrum and right toes; [MEDICAL CONDITION] to right hand. The summary failed to document under Course of Treatment any treatments to the left toes or coccyx. The historical hospital medical records prior to Resident #5's admit to the facility 11/4/19 lacked documentation pertaining to any wounds or treatments for wounds on the resident's coccyx or left toes. The Nursing Admission Screening/History dated 11/4/19 at 5:01 p.m. recorded a full head-to-toe nursing assessment completed on Resident #5. The Assessment Tab of the electronic record printed 7/29/20 reflected this initial nursing assessment completed by Staff T, Licensed Practical Nurse (LPN). The clinical record lacked any indication a Registered Nurse (RN) completed or participated in the initial nursing assessment. The assessment documented the resident resided in room [ROOM NUMBER]-1; fell and broke her wrist at home; alert and oriented to person, place, time, and situation; and both right and left legs normal color, normal temperature, and she could bear weight on legs. The assessment recorded the skin assessment done by Staff D, LPN; and pain rated an 8 out of 10 (zero no pain and ten the worst pain imagined). The resident reported pain located mostly in her bottom but some pain in her right arm. The Skin Nurse Weekly Skin Observation Tool dated 11/4/19 at 2:28 p.m., written by Staff D, documented the following 5 pressure sores present at admit: a. left foot 3rd digit, stage II pressure that measured 1.2 centimeters (cm) by 1.2 cm. b. left foot 4th digit, unstageable pressure that measured 1.3 cm by 0.8 cm. c. left foot 5th digit, unstageable pressure that measured 0.5 cm by 0.4 cm. d. left foot top of 2nd digit, area noted as pressure but not staged that measured 0.4 cm by 0.3 cm. e. sacrum, stage II pressure that measured 0.6 cm by 0.3 cm by 0.3 cm depth. Staff D documented the left foot 3rd digit deep purple/black on approximately 2/3rd of the toe. The foot cherry red, cool to the touch, blanched fair. Slough present on the 4th and 5th digits with foam between the resident's toes when she arrived to the facility. The resident's family member stated he cared for the areas at home like that and did not treat them. The skin surrounding the sacrum very red with wound base meaty red, wound edges very macerated. Staff D recorded she faxed out to the doctor to request a new treatment. On 7/30/20 at 12:05 p.m., the Director of Nursing (DON) stated the facility kept all skin assessments either in the electronic record or on paper. The DON confirmed if a resident discharged then all skin assessments documented on paper should be in the closed hard chart record. The DON not aware of any other areas in the facility where skin assessments documented or stored. The clinical record lacked documentation of any other full nursing assessments pertaining to the wounds located on the sacrum and left toes. The Braden Scale for Predicting Pressure Sore Risk dated 11/5/19 at 7:57 a.m. documented a score of 17 that indicated the resident at risk. The Order Summary Report signed 11/6/19 contained all the active physician's orders [REDACTED]. The report lacked orders for treatments to any of the resident's 5 pressure sores located on her sacrum and left toes. The orders lacked any orders pertaining to compression stockings/hose. The November 2019 Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked documentation of any pressure sore treatments. The MAR and TAR lacked documentation pertaining to compression stockings/hose. The clinical record contained daily Skilled Charting nursing assessments from 11/5/19 thru 11/9/19. The Skilled Charting form contained a section to document a complete head-to-toe physical assessment of a resident and included these sub-sections: vital signs; Level of Consciousness/Orientation/Cognition; ADLs/Functional Status; Mood and Behavior; Bladder; Bowel; Skin/Wound; Respiratory; Cardiovascular; Neurological/Sensory/Communication; Pain; Medications/Orders; and Skilled Services. The Assessments Tab of the electronic record printed 7/29/20 reflected who wrote each assessment. The Skilled Charting nursing assessment dated [DATE] at 1:47 p.m. written by Staff G, RN. Staff G documented under Skin/Wound Care the resident with treatable wounds on left toes and coccyx and no treatment order at that time. The nurse wrote the area assessed and sent for treatment order. The Cardiovascular section recorded peripheral pulses palpable with mild [MEDICAL CONDITION] to bilateral lower extremities (BLE), bilateral feet dark red and cooler to touch, left hand red and cooler to touch, and unable to obtain accurate O2 (oxygen) saturation reading. The Pain section recorded the resident rated her pain at a 5 out of 10, location of pain left blank, [MEDICATION NAME] (pain medication) given after therapy and while doing treatment per request, and when asked if having pain at breakfast the resident said no. The Skilled Charting nursing assessment dated [DATE] at 2:43 p.m. written by Staff G. Staff G documented under Skin/Wound Care the exact same information as 11/5/19 assessment; the resident with treatable wounds on left toes and coccyx, no treatment order at that time, the area assessed, and sent for treatment order. The Cardiovascular section documented the exact same information as the 11/5/19 at 1:47 p.m. assessment; peripheral pulses palpable with mild [MEDICAL CONDITION] to BLE, bilateral feet dark red and cooler to touch, left hand red and cooler to touch, and unable to obtain accurate O2 sat. The Pain section recorded a pain rating of 5, the location left blank, and noted [MEDICATION NAME] given per request at lunch time. The Skilled Charting nursing assessment dated [DATE] at 12:49 p.m. written by Staff K, LPN. Staff K documented under Skin/Wound Care the resident with treatable wounds and no other information recorded. The Cardiovascular section documented peripheral pulses palpable, mild [MEDICAL CONDITION] to BLE, and bilateral feet dark red and cooler to touch. The Pain section recorded the resident verbalized pain but no rating, location, or notes recorded. The Skilled Charting nursing assessment dated [DATE] at 1:36 p.m. written by Staff K. Staff K documented nothing under Skin/Wound Care as the section left blank. The Cardiovascular section recorded the exact information as the 11/7/19 at 12:49 p.m. assessment; peripheral pulses palpable, mild [MEDICAL CONDITION] to BLE, and bilateral feet dark red and cooler to touch. The Pain section recorded the resident verbalized pain but no rating, location, or notes recorded. The Skilled Charting nursing assessment dated [DATE] at 1:19 p.m. written by Staff L, LPN. Staff L documented under Skin/Wound Care the resident with treatable wounds, location left blank, and unable to assess wounds due to cast placement. The Cardiovascular section documented peripheral pulses palpable, mild 1+ [MEDICAL CONDITION]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER VALLEY LIVING AND REHAB	400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) (mild pitting, slight indentation, no perceptible swelling of the leg) present, and the resident remained up in wheelchair much of the shift and offered the use of recliner but declined. The Pain section recorded the resident denied pain or discomfort that shift. The Medications section recorded the resident continued antibiotic for skin/wound management with no adverse effects. The Pain Level Summary recorded only numerical numbers for pain rated on a 0 to 10 scale and no other characteristics of pain or its location: a. 11/4/2019 at 5:10 p.m. - 10 b. 11/4/2019 at 6:24 p.m. - 10 c. 11/4/2019 at 10:41 p.m. - 8 d. 11/5/2019 at 12:30 a.m. - 3 e. 11/5/2019 at 5:32 a.m. - 7 f. 11/5/2019 at 10:10 a.m. - 0 g. 11/5/2019 at 10:30 a.m. - 5 h. 11/5/2019 at 2:35 p.m. - 3 i. 11/5/2019 at 4:25 p.m. - 7 j. 11/5/2019 at 6:18 p.m. - 5 k. 11/6/2019 at 1:23 a.m. - 5 l. 11/6/2019 at 4:32 a.m. - 0 m. 11/6/2019 at 5:20 a.m. - 5 n. 11/6/2019 at 7:56 a.m. - 4 o. 11/6/2019 at 12:11 p.m. - 6 p. 11/6/2019 at 1:55 p.m. - 4 q. 11/6/2019 at 5:10 p.m. - 5 r. 11/6/2019 at 9:09 p.m. - 3 s. 11/7/2019 at 5:11 p.m. - 8 t. 11/7/2019 at 7:05 p.m. - 6 u. 11/7/2019 at 8:49 p.m. - 10 v. 11/7/2019 at 11:06 p.m. - 9 w. 11/8/2019 at 5:28 p.m. - 8 x. 11/8/2019 at 8:08 p.m. - 6 y. 11/9/2019 at 3:30 a.m. - 8 z. 11/9/2019 at 5:16 a.m. - 3 The clinical record only contained correlating, partial pain assessments on the dates highlighted in bold above. The Progress Notes only described the location of the pain on the following dates; otherwise, the clinical record lacked thorough pain assessment information: a. 11/4/19 at 5:10 p.m. noted in the initial nursing assessment pain located mostly in her bottom and some in right arm b. 11/5/19 at 4:25 p.m. noted complaints of right wrist pain c. 11/5/19 at 11:25 p.m. noted complaints of right wrist pain with [MEDICATION NAME] given with some relief and no further pain d. 11/6/19 at 5:20 a.m. noted arm pain e. 11/6/19 at 5:10 p.m. noted arm pain f. 11/7/19 at 5:11 p.m. noted right arm pain g. 11/7/19 at 8:49 p.m. noted right arm and buttock pain h. 11/8/19 at 5:28 p.m. noted right arm and coccyx pain i. 11/9/19 at 6:58 a.m. noted complaints of positional pain while in bed throughout the night The Progress Notes lacked documentation of an initial admit note to record the resident's arrival to the facility and status/circumstances of her arrival on 11/4/19. The Progress Notes contained the following documentation: a. On 11/5/19 at 5:32 a.m., [MEDICATION NAME] medication given for increased pain. b. On 11/5/19 at 5:46 a.m. Staff R, LPN, wrote a skilled note. Staff R documented the resident skilled for right arm fracture with surgical repair and complaints of pain rated 7 out of 10 that shift. The resident's skin with several existing skin issues noted, including pressure ulcer to coccyx, toe discoloration with foam in place, and bruising noted to left wrist at that time. Staff R recorded the resident's cast in place to right arm with no complaints of numbness or swelling. The entry lacked indication of which toes affected or status of the sores. c. On 11/5/19 at 1:54 p.m. Staff G, RN, wrote a Health Status Note. Staff G recorded she spoke to the resident's primary physician office about allergies [REDACTED]. d. On 11/5/19 at 11:25 p.m. Staff O, LPN, wrote a Skilled Note. Staff O documented the resident complained of pain once and [MEDICATION NAME] given. Staff O recorded the resident with bruising to left hand/wrist area, pressure ulcer to coccyx, and pressure areas to left toes. The entry lacked indication of which toes affected or status of the sores. e. On 11/6/19 at 4:08 a.m., Staff R wrote a Skilled Notes. Staff R documented the resident experienced pain with pain medication given. Staff R recorded the resident continued with bruising to left wrist, pressure ulcer to coccyx, and discoloration to toes. The entry lacked indication of which toes affected or status of the sores. f. On 11/7/19 at 12:04 a.m., Staff O wrote a Skilled Note. Staff O documented the resident experienced pain once and [MEDICATION NAME] given. Staff O recorded the resident continued with bruising to left hand/wrist area, pressure ulcer to coccyx, and pressure areas to left toes. The entry lacked indication of which toes affected or status of the sores. g. On 11/7/19 at 7:15 a.m. Staff H, LPN, wrote a Skilled Note. Staff H recorded the resident with pressure ulcer to coccyx and pressure areas to toes. The entry lacked indication of which toes affected or status of the sores. h. On 11/7/19 at 12:47 p.m. Staff K, LPN, wrote a Health Status Note. Staff K recorded the resident went out for a physician visit to see her hand surgeon. At 4:02 p.m. Staff O documented the resident returned with order to keep the cast clean and dry, try to elevate up in air, and give [MEDICATION NAME] 5 mg (milligrams)/325 mg (narcotic pain medication combined with [MEDICATION NAME]) 1 to 2 tabs every 6 hours as needed for pain. i. On 11/7/19 at 7:03 p.m., Staff O documented a fax received from the resident's hand surgeon ordering Keflex antibiotic medication 500 mg capsule four times a day for 10 days for lacerations under the cast. j. On 11/7/19 at 11:44 p.m., Staff O wrote a Skilled Note. Staff O documented the resident experienced pain with [MEDICATION NAME] given. Staff O recorded the resident continued with bruising to left hand/wrist area, pressure ulcer to coccyx, and pressure areas to left toes. The entry lacked indication of which toes affected or status of the sores. k. On 11/8/19 at 6:48 a.m., Staff H wrote a Skilled Note. Staff H documented the resident complained of pain at the beginning of the shift rated a 9 out of 10 and Tylenol given with [MEDICATION NAME], which was effective. Staff H recorded the resident continued with pressure areas to coccyx and to left toes. The entry lacked indication of which toes affected or status of the sores. l. On 11/8/19 at 11:25 p.m., Staff O wrote a Skilled Note. Staff O documented the resident complained of pain rated at an 8 with [MEDICATION NAME] given and some relief voiced. Staff O recorded the resident continued with bruising to the left hand/wrist area, pressure ulcer to coccyx, and pressure areas to left toes. The entry lacked indication of which toes affected or status of the sores. m. On 11/9/19 at 6:58 a.m., Staff H wrote a Skilled Note. Staff H documented the resident complained of positional pain while in bed throughout the night, [MEDICATION NAME] given, and the resident stated relief. Staff H recorded the resident continued with pressure areas to coccyx and left toes. The entry lacked indication of which toes affected or status of the sores. n. On 11/9/19 at 1:52 p.m. Staff L, LPN, wrote a Health Status Note. Staff L documented the resident sat in her recliner with her family member standing at the foot of the recliner with her sock off the left foot. The family member upset about the appearance of the toes on the foot stating the toes not that way when the resident in the hospital, now much worse. The family member took pictures of the foot. Staff L wrote she reassured the family member they monitored the toes and would leave the compression hose off the right leg and the family member voiced they wanted the socks on but they didn't need to be so tight nor did her shoes need to be on. Staff L wrote she attempted to educate the family member the reasoning and use of compression stockings and assured them the resident could go without shoes except when transferring. Staff L recorded she called Staff D, LPN/Skin Nurse, to update on the situation. The entry lacked documentation of a full skin assessment, description of what the toes looked like, measurement of the wounds, location of the wounds, or notification to the physician. o. On 11/9/19 at 2:10 p.m., Staff L documented the family member reported they called the physician and the physician wanted to speak to the nurse. The entry recorded the nurse updated the physician on the appearance of the toes and the physician wanted the resident sent to the ER (emergency room) for evaluation of the area. At 2:20 p.m., the resident left the facility and transported to the ER. p. On 11/9/19 at 9:12 p.m. the entry recorded the resident admitted to the hospital [MEDICAL CONDITION] (infection in the blood) due to [MEDICAL CONDITION] (inflammation of the skin) with necrosis (death of body tissue) of toes and problems with the cast (right arm). q. On 11/20/19 at 4:34 p.m., a Social Service entry recorded the resident's wheelchair picked up from ICU (Intensive Care Unit). Review of the clinical record revealed the record lacked documentation the resident's primary physician notified of the resident's 5 pressure sores as recorded on the initial skin assessment or the notation of a deep purple/black toe discoloration. The resident's family member sent a text message with a picture of the left foot to the physician on-call for the primary care physician on Saturday, 11/9/19 at 2:14 p.m. The family member wrote to the physician they wanted the doctor to see that the facility did not provide care of the foot all week since Monday (11/4/19). Review of the pictures taken by Resident #5's family member, dated 11/9/19 on the pictures, revealed the left foot with wounds. The 2nd toe with a scabbed, darkened area on the top of the toe; the 3rd toe mostly deep purplish and black in color; the 4th toe all black, appeared swollen; and the 5th toe not visible due to soiled gauze wrapped around the toe and in-between the 2nd and 3rd toes that appeared stuck in place without tape. The pictures revealed the left foot with redness darker in color on the top of the foot. The ED (Emergency Department) Provider Notes dated 11/9/19 at 3:58 p.m. documented the resident presented with foot pain, skin breakdown of 3rd and 4th digits on left foot blackening, and redness and swelling of bilateral feet. The Clinical Impression and Disposition dated 11/9/19 at 7:35 p.m. diagnosed [MEDICAL CONDITION] due to [MEDICAL CONDITION]; toe necrosis; problem with fiberglass cast; and acute [MEDICAL CONDITION] with [MEDICAL CONDITION] (low blood oxygen levels). The Hospitalist Discharge Summary dated 11/26/19 at 2:13 p.m. recorded the following: a. Hospital Course - the patient (Resident #5) presented to the hospital with left foot pain and blackish discoloration in her toes. Vascular surgery consulted. The patient started on [MEDICATION NAME] drip (blood thinning medication). Patient had left SFA (Superficial Femoral Artery), popliteal artery atherectomy (procedure that utilizes a catheter with a sharp blade on the end to remove plaque from a blood vessel) and angioplasty (procedure to open narrowed or blocked blood vessels). Patient had stent placed to left popliteal artery. Podiatry consulted and she had a transmetatarsal amputation (surgery to remove part of foot) left foot on 11/15/19. The patient developed C.Diff ([MEDICAL CONDITION] - type of infection) during hospitalization . The patient started on [MEDICATION NAME] orally (antibiotic medication). Diarrhea improved. Tissue culture from her foot [MEDICAL CONDITION] ([MEDICAL CONDITION]-Resistant Staphylococcus Aureus) and Proteus (types of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER VALLEY LIVING AND REHAB	400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) bacteria). Patient was on [MEDICATION NAME] and [MEDICATION NAME] (two additional types of antibiotic medications). Infectious Disease consulted and following during hospitalization . Patient developed respiratory distress during hospitalization attributed to [MEDICAL CONDITIONS] (fluid in lungs) and possible aspiration pneumonia. Patient intubated on 11/22/19 and started on tube feeds. The patient passed away on 11/26/19 at 7:58 a.m. b. The primary cause of death documented as shock, [MEDICAL CONDITION], [MEDICAL CONDITIONS], and pneumonia. The secondary causes of death documented as left toes gangrene status [REDACTED].difficile. The Certificate of Death dated 11/26/19 at 7:58 a.m. documented the immediate cause of death shock due to or as a consequence of [MEDICAL CONDITION] due to or as a consequence of [MEDICAL CONDITIONS] with underlying cause of pneumonia and other significant condition of left toes gangrene status [REDACTED]. Physician Interview On 8/4/20 at 10:30 a.m., the nurse for Resident #5's primary care physician reviewed the clinic's medical records for Resident #5. The clinic representative stated the clinic received a fax on 11/4/19 regarding a message about the resident's vitamin B12 injection, and a call from the facility pharmacy regarding clarification of [MEDICATION NAME] (narcotic pain medication) and [MEDICATION NAME] medication. The clinic representative reported on 11/5/19 the clinic received a fax related to the [MEDICATION NAME] being too strong for the resident but nothing about a black toe. The clinic representative reported on 11/6/19 the facility faxed the resident's immunization records. The clinic representative stated they did not scan every fax if they did not have to address anything, but otherwise they scanned the faxes into the record if orders written. The clinic representative reported they received a call on 11/9/19 from the resident's family member about Resident #5's toes. On 8/24/20 at 1:23 p.m., Resident #5's primary care physician reported he never examined the resident while the resident resided at the facility and he did not see the resident's toes. The physician stated in his opinion, a black toe is considered something critical requiring a call to the physician rather than a fax. The physician responded it would depend on the strength of the resident's ted hose whether or not the hose are contraindicated to wear on an extremity with a wound present. The physician responded the facility called with any headaches, small bruises, or falls without injury, so he would not know why they would not call to report a black toe as it would indicate a blood flow issue. On 8/13/20 at 4:08 p.m., the podiatrist who performed the amputation for Resident #5 responded he remembered the resident vividly and reviewed the resident ' s medical records. The podiatrist responded to a question about if the resident ' s outcome could have changed if staff notified the physician of the deep purple/black discoloration at the time of admit 11/4/19. The podiatrist stated the 3rd and 4th toes completely black and the 5th starting to get black when he evaluated the resident and no way the symptoms reported as seen on 11/9/19 would have happened overnight. The podiatrist commented maybe 1 toe but not all 3. The podiatrist stated what should have happened was as soon as the nurse documented she observed deep purple/black discoloration she should have called the resident ' s primary physician. The podiatrist stated if the primary physician had contacted him at that point, the podiatrist would have gotten the resident seen that day. Family Interview On 8/4/20 at 11:24 a.m., Resident #5's family member reported the resident seen at the wound clinic prior to admit to the facility 11/4/19 for a chronic, coccyx ulcer located at the top of her rectum. The family member denied the wound center seeing the resident for pressure sores on her toes. The family member stated the hospital gave them a discharge paper that directed to keep eye on the baby toe and watch for gangrene. The family member said they gave the paper and the orders from the hospital to the facility. The family member said they noticed a pink spot on the resident's baby toe. The family member stated they wanted the hospital doctor to do something but they never took any blood work and did anything about it. The family member reported the resident wore compression socks on her feet at home ordered by their family doctor related to the resident's heart issues. The family member said the facility held a big meeting with them the day before they observed the resident's feet on 11/8/19. The family member reported the resident going in and out of therapy and supposed to keep her foot elevated so they did not swell but the facility not doing that and not keeping the arm with a cast elevated in the air. The family member said the resident sat in a chair, kept the arm down, and the arm swelled up as not kept in the sling. The family member voiced the facility did not provide care for their mother. The family member recalled the resident's pinky toe had just the one spot that got bigger by the end of stay. The family member identified the resident on narcotic pain medication and so made no noise of pain complaints when asked why she wore compression hose. The family member reported the family physician mainly recommended wearing the hose a long time before the hospitalization in October 2019. The family member said they asked the facility everyday if they were checking the resident's foot. The family member stated they could not believe what they saw when they took off the socks/compression hose on 11/9/19. The family member stated the resident reported to them the staff did not remove her compression hose since she admitted to the facility and told them the night before the facility put her to bed in her socks and shoes. The family member stated they voiced disbelief to the resident that the facility did not remove the hose during her 5-day stay, but upon removing the socks, they could not believe what they found. The family member recalled taking off the right compression hose first, everything okay, then they took off the left compression hose sock and the resident stated ow, ow. The family member stated the resident reported the foot had been hurting but she did not say anything. The family member reported the area on the foot reddish in color when they last saw it at the hospital and then the whole toes black; no way it just happened. The family member reported they called the on-call physician for the family doctor on 11/9/19 and sent pictures to notify the doctor of the concern and the doctor ordered the resident sent to the ER for evaluation. The family member forwarded a text message of a screen shot of the message and picture sent to the doctor on 11/9/19. The family member commented the resident admitted to the facility just for therapy and then to go back home; the facility should have kept an eye on the resident's foot. The family member reported the hospital cut off the resident's toes as diagnosed with [REDACTED]. The family member said the resident passed away after four different antibiotic treatments. The family member again stated it looked nothing like that when the resident admitted to the facility and she only had one spot with spacers between the toes. In a follow-up interview on 8/4/20 at 1:27 p.m., Resident #5's family member reported the resident wore the type of compression hose with an enclosed toe area so there was no opening to view the toes. Staff Interviews On 7/31/20 at 10:34 a.m. Staff D, LPN, recalled working with Resident #5. Staff D stated when Resident #5 admitted to the facility she was a mess, very pleasant, withdrawn, and had some wounds but Staff D could not recall all the wounds. Staff D commented she knew skin issues present on toes and groin area. Staff D confirmed the left toes looked purple and black on the day of admit when she completed the initial skin assessment. Staff D stated she sent a fax
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on chart review and interviews the facility failed to ensure that all residents recieve sufficient fluid intake to maintain proper hydration and health for 1 of 9 residents reviewed (Resident #4). The facility admitted to the facility 12/30/19 with gastric tube feeding orders that did not meet his nutritional & fluid needs. The facility failed to follow up with the dietician to ensure the resident received adequate nutritional and fluid needs. The facility failed to ensure staff was consistent with water flushes and di not have a policy for them. On 1/24/20 the resident admitted to the hospital severely dehydrated with an [MEDICATION NAME] level of 2.2 (low) A low [MEDICATION NAME] can identify malnutrion. The facility reported a census of 44 residents. Findings include: According to the Minimum Data Set ((MDS) dated [DATE], Resident # 4 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the MDS the resident required the use of a Hoyer lift for transferring, assistance of two staff with dressing, bathing and toileting. He did not receive any food or fluids orally and had a feeding tube. The care plan for Resident #4 dated 1/14/20 addressed risk areas that included altered nutrition related to enteral feedings and aspiration. The care plan identified the resident with self-care deficits with impaired physical mobility, impaired communication and the care plan directed staff to assess the residents' non-verbal behaviors such as restlessness and facial expressions. The care plan revealed the resident chose not to wear his dentures and staff were instructed to provide frequent oral care and oral inspection. Staff were directed to monitor and access the calories, fluid and protein needs of Resident #4 and to monitor for signs and symptoms of dehydration such as dry mouth, skin, eyes, and decreased urinary output. A physician's orders [REDACTED]. The orders included: Bolus tube feedings [MEDICATION NAME] 1.5-290cc followed by 50cc flush five times a day. Clean gastrostomy tube (g tube) every day, daily weights, oxygen as needed (PRN) to keep saturations above 90% check when appears symptomatic. Sacral wound cleanse with soap and water apply [MEDICATION NAME] ag (a sterile dressing with silver used to cover acute and chronic wounds) followed by dressing every day. Suction orally PRN as needed secretions and congestion. Up 2 times a day for therapies and back to bed for pressure relief to sacrum. Up in chair no longer than 2 hours at a time. Daily weights related to fluid retention. A review of the transfer records from the Madonna Center signed by the referring physician and dated 12/30/19, revealed several orders that staff did not transcribe into the residents record: 1) Provide oral hygiene every 2 hours. 2) [MEDICATION NAME] (anti-fungal) suspension to be given 4x a day orally for oral cares to prevent thrush. The omission was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER VALLEY LIVING AND REHAB	**400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) discovered and entered into the electronic chart on 1/10/20. 3) Vital signs every 3 hours. A review of the medical chart revealed several as needed orders (PRN) that were seldom used: 1) [MEDICATION NAME] Nebulizer every two hours as needed for shortness of breath, this was not used at all. 2) [MEDICATION NAME] liquid 100millegrams per 5 milliliter as needed for secretions was only used three times during the residents stay. 3) Suction every 6 hours as needed for increased secretions. The electronic chart contained three references to staff suctioning the resident up until 1/23/20: on 1/8/20, 1/11/20, and 1/19/20. One nursing note on 1/22 indicated that the resident had refused suctioning. The baseline care plan dated January 2, 2020 lacked instruction regarding daily weights, the need for suctioning of secretions, the use of pressure reduction adaptive equipment to assist with healing of sacral wound, supplemental oxygen use or percutaneous endoscopic gastrostomy (PEG) tube daily cleaning. The resident admitted to the facility on [DATE] and the care plans did not address oral cares until 1/14/20 and did not address suctioning needs at all. According to the admission nutritional assessment dated [DATE] the recommendations for nutrition and fluid were as follows: Resident is difficult to understand, current feeding provides: 2175 calories, 90 grams of protein, 1160 cubic centimeter (cc) free water plus flushes after of 50 cc and with medication of approximately 450 cc for total fluid of 1600 cc average per day. Nutritional needs with pressure areas; 2400-2600 calories, 88-105 gram protein and 2000-2300 cc fluid. Will follow weights and any plans for oral intakes and consider a feeding increase to 320 cc [MEDICATION NAME] 1.5, 5 times daily with 60 cc before and after each feeding and 30 cc before and after each med pass. Would provide 2400 calories, 100 grams protein. In a telephone interview on 8/5/20 at 1:10 PM, the dietician stated that she remembered giving the recommendations for tube feedings for Resident #4. She said that she followed up with the facility in an email to request an increase in food and fluids if oral intake was not going to be possible. She said that many times when a resident comes to a facility with a feeding tube they may quickly move toward oral feedings, however, if that isn't in the plan, the tube feedings may need to be increased to meet the needs of the resident. The dietician said that she expected the facility would have a plan if/when they would trial oral intake and assess if the resident was healthy enough to start an oral trial. If that was not possible then the tube feedings would have to be increased. A review of the email sent to the facility on [DATE] from the dietician to Staff D revealed that the dietician communicated to the facility that the resident's feedings did not meet his nutritional needs with pressure areas. She indicated that if oral intake was not established soon, they should fax out for an increase from [MEDICATION NAME] 1.5 290 cc 5x daily to 320 cc 5x daily and increase flushes to 60 cc water before and after each feeding and with the standard medication pass. Resident #4 admitted to the hospital on [DATE] with [MEDICAL CONDITION], dehydration, aspiration pneumonia, [MEDICAL CONDITION] and acute kidney injury. A review of the hospital laboratory records dated 1/24/20 revealed that the residents BUN was 84 (8-25 normal range). The residents baseline on 12/28/19 was 38.2. Creatinine was 1.6 (0.6-1.4 normal range). The residents baseline range on 12/28/19 was 1.02. Sodium 153 (136-144 normal range). The residents baseline range on 12/28/19 was 133 and chloride 120 (normal range 98-108). The residents baseline on 12/28/19 was 103. A hospital history and physical dated 1/24/20 revealed an [MEDICATION NAME] level of 2.2 (low). [MEDICATION NAME] is a protein found in the blood. A low [MEDICATION NAME] can identify malnutrition. A hospital consultation dated 1/24/20 revealed the reason for the consultation as: Acute kidney injury with [MEDICAL CONDITIONS] and dehydration. The impression included: acute kidney injury with free water deficit and severe dehydration In an interview with the DON on 8/4/20 at 8:45 AM, the DON looked at the follow up email from the dietician with the recommendations to increase food and fluids if he was unable to transition to oral intake. She said the note would have gone directly to the Resident Care Coordinator (RCC) that person had been responsible to monitor and follow up. In a telephone interview on 8/3/20 3:00PM, Staff D LPN (licensed practical nurse) said she remembered Resident #4, specifically that he required suctioning, that he had some paralysis, and that he was a big guy. She said she was the RCC at that time and her responsibilities included doing some skin assessments and checking to see whatever else the nurses needed; if they needed advice on anything. When asked if she was solely responsible for skin assessments she said no, it was usually the nurses that would do the skin assessments but she would do them sometimes. She said that she did not remember the wound that Resident #4 had on his sacrum. When asked if there was anything else about Resident #4 that she remembered she said that the resident did not function at the level that the referring facility described. She said the resident's daughter told them he would sit on the side of the bed and play cards but he was far from that description. However, she said she believed that Pioneer had the resources and training to care for him. On 8/3/20 2:10, Staff C RN, recalled the resident because he was the husband of another resident that resided at the facility for a long time. She did remember that she completed the suctioning on him a couple of times when he experienced difficulty clearing phlegm. She remembered applying treatments to his bottom and said that at that time, it was Staff D that would do the measuring of the wounds and the nurses would let Staff D know if they thought any areas got worse. Staff C said since they did not have a clinical coordinator at the time of the survey, she would take any concerns to the DON and she would call the doctor with any resident concerns that needed the attention of the doctor. On 8/4/20 12:40 Staff E, occupational therapist (OT), said she remembered the resident because he was at a different level of functioning than what they expected. She said the resident's daughter described some of the things he could do and they wondered if he'd had another stroke that caused more damage before he came to the facility. Staff E said she hadn't been concerned that the resident wasn't getting repositioned and she believed the staff tried different techniques to keep him off of the pressure sore area. On 8/4/20 at 12:46 p.m. Staff F, speech therapist, said he remembered Resident #4. He said he'd had some concerns that staff did not provide oral cares so he addressed this with nursing. He said the residents tongue looked like he developed thrush and he had saliva that was solidified behind his teeth. Staff F said that it had been early on in the residents stay and that once he addressed it, the oral hygiene improved. He said that initially, the resident had been resistive to cares. On 8/4/20 at 3:10 PM, Staff H said he remembered Resident #4, specifically that he completely depended on staff, post stroke. Staff H said that he worked nights and at that time and the resident would occasionally talk to him whereas during the day he didnt respond. Staff H remembered doing some treatments to the resident's sacrum area and thought it was a [MEDICATION NAME] treatment. He did not remember having any concerns that the ulcer got worse. He said the resident would scratch himself often and had long finger nails, and he clipped them a couple of times. Staff H recalled the night before the resident went to the hospital because he had been in the room for almost an hour suctioning secretions. Staff H said that a CNA told him that the resident was struggling to breathe so they went in and did the suctioning. When asked if he remembered ever seeing signs or symptoms that the resident may have been dehydrated and he said he did not remember having any concerns in that area. On 8/5/20 at 2:15 PM LPN Staff O said that she would stictly go by whatever the physician orders [REDACTED]. She was not aware of any facility policies or standards on how much water to give with medications. Staff O said one of the residents has a 150cc flush after feedings and she thought it was 15-30cc before, with and after medications. She added that she would always go by the physician order [REDACTED]. In an interview with LPN Staff Q on 8/5/20 at 2:20PM, she said she would use 90cc before and after medication for a resident with a PEG tube, but would do whatever the order is in the electronic record. In an interview on 8/6/20 at 11:55 AM DON acknowledged the missed items on the transfer orders from Madonna Rehabilitation Center. She said that it was the responsibility of the patient care coordinator to enter transfer orders. The person that was in this position was terminated the end of June and since that time, the DON had been entering orders. She stated that the expectation is that all physician orders [REDACTED]. In an email communication with the administrator on 8/11/20 at 4:28 she indicated that the facility did not have any policies on suctioning procedure or on oral cares for residents who have feeding tubes.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on chart and policy review and interviews the facility failed to ensure that residents receive respiratory and oral care consistent with professional standards of practice for 1 of 9 residents reviewed (Resident #4). The facility reported a census of 44 residents. Findings include: A Minimum Data Set ((MDS) dated [DATE] revealed Resident # 4 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the MDS the resident required the use of a Hoyer lift for transferring, assistance of two staff with dressing, bathing and toileting. He did not receive food or fluids orally and utilized a feeding tube. The care plan for Resident #4 dated 1/14/20 addressed risk areas that included altered nutrition related to enteral feedings and aspiration. The care plan identified the resident with self-care deficits of impaired physical mobility, impaired communication and directed staff to assess the residents' non-verbal behaviors such as restlessness and facial expressions. The care plan revealed the resident chose not to wear dentures and staff were instructed to provide frequent oral care and oral inspection. Staff were directed to monitor and access the calories, fluid and protein needs of Resident #4 and to monitor for signs and symptoms of dehydration such as dry mouth, skin, eyes, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER VALLEY LIVING AND REHAB	**400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) decreased urinary output. According to the physician's orders [REDACTED]. Orders included: Bolus tube feedings [MEDICATION NAME] 1.5-290cc followed by 50cc flush five times a day. Clean gastrostomy tube (g tube) every day, daily weights, oxygen as needed (PRN) to keep saturations above 90% check when appears symptomatic. Sacral wound cleanse with soap and water apply [MEDICATION NAME] ag (a sterile dressing with silver used to cover acute and chronic wounds) followed by dressing every day. Suction orally PRN as needed secretions and congestion. Up twice a day for therapies and back to bed for pressure relief to sacrum. Up in chair no longer than 2 hours at a time. A review of the transfer records from the Madonna Center signed by the referring physician and dated 12/30/19, revealed several orders that did not get transcribed into the residents record: a) Provide oral hygiene every 2 hours. b) [MEDICATION NAME] (anti-fungal) suspension to be given 4x a day orally for oral cares to prevent thrush. The omission was discovered and entered into the electronic chart on 1/10/20. c) Vital signs every 3 hours. A review of the medical chart revealed several as needed orders (PRN) that were seldom used; a) [MEDICATION NAME] Nebulizer every two hours as needed for shortness of breath, this was not used at all. b) [MEDICATION NAME] liquid 100millegrams per 5 milliliter as needed for secretions was only used three times during the residents stay. c) Suction every 6 hours as needed for increased secretions. The electronic chart contained three references to suctioning having been completed up until 1/23/20; on 1/8/20, 1/11/20, and 1/19/20. One nursing note on 1/22/20 indicated that the resident had refused suctioning. The baseline care plan dated January 2, 2020 lacked instruction regarding daily weights, the need for suctioning of secretions, the use of pressure reduction adaptive equipment to assist with healing of sacral wound, supplemental oxygen use or percutaneous endoscopic gastrostomy (PEG) tube daily cleaning. The resident admitted to the facility on [DATE] and the care plan did not address oral cares until 1/14/20 and did not address suctioning needs at all. Resident #4 admitted to the hospital on [DATE] with [MEDICAL CONDITION], dehydration, aspiration pneumonia, [MEDICAL CONDITION] and acute kidney injury. A review of the hospital speech therapy records dated 1/27/20 revealed that they found the patient to have a dry oral cavity with redness on posterior pharyngeal wall with dried yellow secretions on the soft palate. A review of the nursing documentation leading up to the resident's admission to the hospital on [DATE] revealed the following notations related to respiratory status: 1/14/20 at 3:37 oxygen saturation 91% on room air. Lung sounds congested occasional cough, swab done orally. 1/15/20 at 23:12 lung sounds clear breathing through the mouth, mouth very dry. 1/17/20 15:33 lung sounds congested no cough or sputum present. 1/18/20 at 21:08 lung sounds diminished no suctioning provided. 1/21/20 15:15 lung sounds congested, able to clear with coughing 1/22/20 at 4:05 resident continues to have cough noted, no complaints of shortness of breath. 1/23/20 at 10:21 the residents oxygen saturation was 83% on room air no audible secretions or wheezes. Able to get oxygen to 93% with 3 liters of supplemental oxygen. 1/23/20 at 23:35 resident is unable to let needs known to staff, must anticipate needs. Lung sounds clear with occasional coughing, breathing through mouth, coughing up a lot of phlegm. Attempted to suction but unable to get any phlegm out. 1/24/20 at 9:02 a.m. nurse alerted that resident appeared pale and oxygen saturation was 78-80%. Blood pressure 100/54 respirations 28 and labored, heart rate 77 and regular. Oral cares completed with suctioning with gross amount of phlegm removed. Oxygen saturation then increased to 95% without supplemental oxygen, 1/24/20 at 2:23 p.m.resident required suctioning several times this shift. Secretions unable to be fully cleared by suctioning. Resident coughed and able to cough up phlegm. Mouth care done every 2 hours with suctioning. Skin is dusky, respirations 28 required 3 liters oxygen with mask to keep above 90%. Periods of shallow breathing. Little air movement in right lower lobe base, rhonchi in posterior bases and rales in front lobes. Call placed to doctor and an order received to go to the emergency room . A review of the speech therapy notes revealed an entry on 1/8/20 at 2:58 PM in which the speech therapist stated that he educated the staff on oral cares. The note went on to say that the therapist performed oral care due to significant build up on palate and tongue. He indicated that staff was educated on completing oral care three times a day to maintain proper oral hygiene. A review of the clinical record revealed a fax dated 1/24/20 sent to the doctor requesting scheduled suctioning every shift in addition to the PRN order. In an interview on 7/30/20 at 12:55, the DON stated that she sent the fax per the request of Staff D LPN. The DON said that at that time, she worked as the Minimum Data Set (MDS) coordinator and had little interaction with the residents on a daily basis. She denied having any knowledge of concerns regarding lack of suctioning but Staff D, LPN Resident Care Coordinator (RCC) requested it because she said that the resident had increased secretions and the PRN suctioning was not being done as often as it should have. The DON said that the responsibility of the RCC was to monitor the floor, making sure assessments were completed to include skin assessments, wound assessments and falls. The DON said that Staff D no longer worked at the facility and her replacement was scheduled to start soon. Staff D was hired in 2018 and was terminated on 6/29/20. In a telephone interview on 8/3/20 3:00PM, when the surveyor asled Staff D about the requested order for scheduled suctioning, she denied having this conversation with the DON. She said that it didn't make any sense to have suctioning scheduled because the resident was suctioned as needed. She said that she completed that task a couple of times herself. When asked if she remembered any of the nurses saying that it was gross and declined to do the suctioning, she said she didn't know of anyone neglecting to do it when the resident needed it. She acknowledged that some may have said it was gross but that did not stop them from doing the task. When asked if there was anything else about Resident #4 that she remembered she said that the resident had not been at the functioning level that the referring facility had described. She said that the daughter told them that he would sit on the side of the bed and play cards but he was far from that description. However, she said she believed that Pioneer had the resources and training to care for him. On 8/3/20 at 1:02 PM, the DON stated that at the time of the admission to the hospital the plan was for Resident #4 to come back to Pioneer, however, they decided that he was at a higher level of need and that this may not have been the best place for him. She said that when they got the referral, the impression they got was that he would be able to participate in therapies and that was not the case. She said that the therapy staff also commented that they had pictured that he would have been at a healthier level to participate in recovery. On 8/3/20 2:10, Staff C RN recalled the resident and that she completed oral suctioning on him a couple of times when he experienced difficulty clearing phlegm. Staff C said that since they did not have a clinical coordinator at the time of the survey, she would take any concerns to the DON and she would call the doctor with any resident concerns that needed the attention of the doctor. Staff C denied knowing of any staff member that refused to suction the resident or leave it for someone else to do because they thought the task was gross. Staff C said that she would always check placement of the tube before feeding and she did not recall getting residual that appeared to be coming from the g tube. She remembered frequent position changes and that he would always had the head of his bed elevated. On 8/4/20 at 12:46 speech therapist Staff F said he remembered Resident #4 and the concerns with the oral cares. He said the resident's tongue looked like he developed thrush with solidified saliva behind his teeth. Staff F said after he addressed this with nursing, the oral hygiene improved and it was early on in his stay so it could have started before his admission to the facility. Staff F said that initially the resident had been resistive to cares. When asked if he had any concerns about suctioning, Staff F said that he thought the nurses performed suctioning as needed as far as he could tell. On 8/4/20 at 7:42 AM, Staff G RN recalled providing cares for Resident #4 and he required total assistance. She remembered he needed suctioning but sometimes he could clear it on his own. She said she suctioned the resident a couple of times. She said she would know if he needed to be suctioned when she heard gurgling sounds from his mouth. She remembered the day he went to the hospital and they could not get all the secretions suctioned out of his mouth at that time and he was struggling. When asked if there had been any of the staff that mentioned it was gross and they refused to suction the resident, she said some had mentioned it being gross but they would do the task. She added the resident required much more care than what they expected but she thought that the facility had the means to care for him. On 8/4/20 at 3:10PM Staff H RN said he remembered Resident #4, specifically that he relied completely on staff, post stroke. Staff H said that he worked at night and the resident occasionally talked to him whereas during the day he did not respond. Staff H remembered doing some treatments to the resident's sacrum area and thought it was a [MEDICATION NAME] treatment. He did not remember having any concerns that the ulcer got worse. He said the resident would scratch himself often and had long finger nails, and he clipped them a couple of times. Staff H remembered the night before the resident transferred to the hospital because he suctioned the resident for almost an hour. Staff H said a CNA (certified nurse aide) told him the resident struggled to breathe so they went in and did the suctioning. Staff H added that he is somewhat repulsed by resident cares that involve saliva identified oral cares as not his favorite thing to do. Staff H remembered feeling somewhat upset that the suctioning wasn't getting done on a regular basis and thought that it should have been done more often. The surveyor asked him about the fax sent to the doctor on the day the resident went to the hospital requesting a scheduled order for suctioning. He said that he was the one that had gone to the DON (MDS coordinator at the time) and asked to get a scheduled order for suctioning so it would get done more often. He acknowledged that it wasn't getting done very often. He said he is not shy about telling his coworkers when work is not getting completed correctly. On 8/4/20 at 8:45 AM, the DON looked at the follow up email from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER VALLEY LIVING AND REHAB	400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) the dietician with the recommendations to increase food and fluids if he was unable to transition to oral intake. She said the note would have gone directly to the Resident Care Coordinator (RCC) for follow up. She said she entered the every two hour oral care nursing order for the resident on 1/24/20. She said she must have decided to do that when the resident went to the hospital and staff spoke of lack of oral cares. She acknowledged the transfer orders from Madonna Rehabilitation that did not get entered in the electronic record. In an email communication with the Administrator on 8/11/20 at 4:28 PM she indicated that the facility did not have any policies on suctioning procedure or on oral cares for residents who have feeding tubes.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and interview the facility failed to complete accurate resident records for 3 of 9 residents reviewed (Residents #8, #9, #1). The facility reported a census of 44 residents. Findings include: 1. A Minumim Data Set ((MDS) dated [DATE] for Resident #8 revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS indicated that the resident had a BIMS score of 9 out of 15, indicating significant cognitive deficit. The MDS identified the resident required limited assistance with the help of one staff for bed mobility, transfers, locomotion and toileting. The care plan for Resident #8 dated 2/7/20, indicated that she received supplemental oxygen related to shortness of breath and change the oxygen tubing weekly. A review of the physician's orders [REDACTED].#8 sitting in her wheel chair with NC oxygen supplement. The oxygen tubing had a piece of tape wrapped around it with the date 7/20/20 written on it. The electronic medical record (EMR) revealed entries made on 7/20/20 and on 7/26/20 that staff changed tubing. Observation on 8/3/20 at 9:00 AM showed the tape dated 7/20/20 still attached to the tubing. A review of the EMR revealed an entry made on 8/2/20 that staff changed the tubing. 2. A MDS dated [DATE] revealed Resident #1 independent with transferring, dressing, ambulation and toileting. The MDS assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive deficit. The resident had [DIAGNOSES REDACTED]. The care plan for Resident #1 dated 1/2/19 contained documentation of potential for alteration in nutrition related to a Percutaneous Endoscopic Gastrostomy (PEG) tube, a history of silent aspiration and history of fluid volume changes. The care plan revealed continuous oxygen supplementation related to [MEDICAL CONDITIONS] and aspiration pneumonia. The care plan documentation included an intervention to change the oxygen tubing weekly. Observation on 7/29/20 at 2:15 PM revealed the resident seated in a chair in her room with nasal cannula oxygen on 4 liters. The tubing contained a piece of tape with the date of 7/13/20 written on it. A review of the clinical chart revealed staff documented they changed tubing on 7/19/20 and 7/26/20. 3. A MDS dated [DATE] revealed Resident #9 without a BIMS score, indicating that the resident had severe cognitive deficits. The resident required extensive assistance with the help of two people for transfer, dressing and toileting and extensive assistance with of one staff for ambulation and eating. Resident #9 had [DIAGNOSES REDACTED]. Physician orders [REDACTED]. The care plan for Resident #9 dated 11/7/19 indicated the resident received Hospice services related to deteriorating physical condition, had a self-care deficit related to dementia and could not perform activities of daily living without assistance. Observation on 7/29/20 at 3:30 PM, showed Resident #9 receiving supplemental oxygen attached per nasal cannula. The tubing contained a piece of tape wrapped around it with a date of 7/20/20. A review of the medical record revealed an entry on 7/26/20, indicating staff changed the tubing on that date. On 8/3/20 at 11:55 AM the Director of Nursing said she was aware of only three residents that are on oxygen supplementation and to her knowledge they have orders to change the oxygen tubing once a week on Sunday night shift. She said the expectation is that staff would date and initial on a piece of tape when completing the tubing change. The DON observed the oxygen tubing for Resident #8 with the tape dated 7/20/20 and then reviewed the EMR documentation. She acknowledged that it was inaccurate documentation and the staff responsible would be disciplined.