STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF TOLEDO	**403 GRANDVIEW DRIVE TOLEDO, IA 52342**

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 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor each resident's preferences, choices, values and beliefs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff and resident interviews the facility failed to meet the needs of 3 of 6 current residents reviewed when they failed to provide access to the call light during meal service.(Resident # 7, #8, and #9). The facility reported a census of 54 residents. Findings include: 1. According to the Minimum Data Set(MDS) Assessment Tool dated 7/13/2020, Resident #7 documented with moderately impaired cognitive abilities, required extensive assistance of staff to transfer from one surface to another and meal set up and supervision - oversight, encouragement or cueing with eating. Observation on 8/25/2020 at approximately 12:20 p.m., revealed the resident in a wheel chair with a lunch served on the tray table. The resident's room had a dual system call light. One call light lay on the floor in between the bed and the wall, the other lay on the bed near the wall. The resident's wheel chair, positioned in between the floor matt near the bed and the recliner made it impossible to navigate his/her wheel close to the bed. The resident reported he/she could not move the wheel chair due to the floor mat being on the floor and the recliner directly behind him/her. The resident reported this prohibited him/her from reaching the call light. The resident talked to visitors on the phone, while the visitors stood at the resident's window behind his/her wheel chair. 2. According to the MDS dated [DATE], Resident #8 documented with severe cognitive impairment, [MEDICAL CONDITION] due to a stroke and [MEDICAL CONDITION]. The MDS revealed the resident required set up assistance and supervision with dining. Observation during the noon meal on 8/25/2020, revealed the resident sat in the wheel chair with a tray table in front of him/her with lunch. The resident ate without staff present and the call light attached to the mattress at the head of the bed, was out of the resident's reach. 3. According to the MDS dated [DATE], Resident #9 required set up assistance and supervision with eating. The resident had [DIAGNOSES REDACTED]. Observation during the noon meal on 8/25/2020 revealed the resident sitting in his/her recliner with a tray table and lunch served. Observation revealed the call light laying on the floor in between the bed and the wall. Staff G, Certified Nurse Aide (CNA) reported the resident independently transferred and ambulated.
F 0686 **Level of harm** - Actual harm **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 observation, clinical record review, resident, and staff interviews the facility failed to notify the Dietician for nutritional interventions or follow Dietary recommendations when given, document skin assessments consistently and accurately to promote healing of facility acquired pressure sores for two of two residents reviewed with pressure sores. Resident #7 and #8. The facility reported a census of 54 Residents. Findings include: 1. According to the Minimum Data Set (MDS) Assessment Tool dated 7/13/2020, Resident #7 documented with moderately impaired cognitive abilities, transferred from one surface to another with extensive assistance of two staff, required supervision and set up assistance with eating, had no risk of developing pressure ulcers/injuries and no unhealed pressure ulcers/injuries. The MDS documented the resident had [DIAGNOSES REDACTED]. The resident record also revealed he/she admitted with Shingles. The Care Plan identified Resident #7 with a nutritional risk initiated 7/15/2020 and directed staff to monitor lab/diagnostic work as ordered, provide and serve diet as ordered, and Registered Dietician (RD) to evaluate and make change recommendations as needed. The Care Plan identified the resident with the potential for impaired skin integrity due to limited mobility, impaired cognition and diabetes. It directed staff to encourage good nutrition and hydration in order to promote healthier skin, monitor/document location, size and treatment of [REDACTED]. Staff were also to encourage resident to wear bilateral pressure reduction boots when not transferring or ambulating and use caution during transfers and bed mobility. The July physician's orders [REDACTED]. On 7/9/2020 - weekly skin assessments to be completed on Thursdays. b. On 8/25/2020 - cleanse area to right heel, apply alginate dressing, cover with bordered gauze and secure with kerlix. c. On 8/22/2020 - crusting procedure (zinc and stoma powder) to coccyx two times a day until healed. The July Medication and Treatment Administration Record (MAR/TAR) included orders related to the resident's wounds: Weekly Skin Assessments on Thursday with documentation of completion on 7/9, 7/16, 7/23, 7/30/2020. The August MAR/TAR included orders related to the resident's wounds: a. Cleanse area to right heel and apply calcium alginate, cover with ABD pad and secure with kerlix daily until healed, ordered 8/22/2020. b. Cleanse area to right heel, apply alginate dressing, cover with bordered gauze and secure with kerlix until healed, ordered 8/25/2020. c. Apply [MEDICATION NAME] to coccyx open areas two times a day (BID) until healed, ordered 7/31/2020 and discontinued on 8/22/2020. d. Apply [MEDICATION NAME] to right heel every three days or sooner if needed every 72 hours, ordered on 8/6 and discontinued on 8/22/2020. c. Crusting Procedure (zinc and stoma powder) BID to coccyx until healed, ordered 8/22/2020. The Progress Notes included: a. On 7/15/2020, Staff A, Dietician reported Resident #7 admitted to skilled due to urinary tract infection, weight stable with intakes on regular diet and thin liquids is adequate with average of 75% intakes. He/she eats independently but does require some supervision and assistance. Per skin report on 7/9/2020, skin intact, no [MEDICAL CONDITION], blood glucose reviewed. No recommendations at this time. Continue weekly weights, and contact dietician with any nutrition concerns. b. On 7/30/2020 staff noted two small areas to coccyx, 0.25 cm (centimeters) and 0.20 cm, surrounding skin brown. Fax sent to physician for treatment. c. On 7/31/2020 the physician ordered [MEDICATION NAME] to areas two times a day until healed. d. On 8/3/2020 the family requested a recliner be placed in the resident's room so he/she could elevate feet during the day. e. On 8/4/2020 the resident moved to a new room. f. On 8/5/2020 Staff A recommended weekly weights and a 2 liter fluid restriction due to weight gain, history of [MEDICAL CONDITION] and currently on [MEDICATION NAME] 20 mg milligrams). g. On 8/5/2020 a CNA noted a blister to the resident's right heel that measured 6.0 cm by 6.5 cm. Staff applied a moon boot and notified the physician via fax. h. On 8/10/2020 staff documented the coccyx wound appeared worse and measured 3.5 cm by 4.5 cm with yellow eschar to wound bed. Resident positioned on side and physician notified. The physician ordered Crusting Procedure to coccyx two times a day until healed. i. On 8/10/2020 the physician ordered right heel treatment: cleanse with normal saline and apply calcium alginate, cover with ABD pad and apply kerlix every day until healed. Staff called the resident's family member and discussed placing a air mattress on the resident's bed and family in agreement. j. On 8/18/2020 the physician ordered Santyl to buttock wound. Physician discontinued order due to insurance non-coverage. The Nursing Admission Assessment effective date 7/8/2020 revealed Resident #7 had no identified pressure areas. Skin Assessments included: a. Weekly skin assessments documenting skin intact: 7/9, 7/16, 7/23, b. On 7/30/2020: Coccyx had two open areas measuring 0.25 cm and 0.2 cm., superficial depth, wound bed pink, scant drainage with no odor. Resident complained of some discomfort. Physician notified. c. On 8/5/2020: Right Heel blister, 6.5 X 6.0 cm. suspected deep tissue injury. Blister intact, top edges pink/red, bottom edge purple. Physician notified. d. On 8/6/2020 - Coccyx: 0.1 X 0.1 pink area noted to coccyx. Area not open. e. On 8/9/2020 - Heel: Pressure area, 3.2 X 4.9 X 0.3, Stage II. Beefy Red, dark purple area to distal part of wound. Distal part of wound boggy. Physician and family notified. f. On 8/10/2020 - Coccyx: 3.5 X 4.5 cm open area to coccyx with yellow eschar, surrounding skin is pink. Physician notified. g. On 8/20/2020 - Sacrum: 3 X 5 cm open area, wound bed with 70% granulation and 30% slough. Pressure injury: 5 X 3 X 0.4 cm, Stage II. h. On 8/23/2020 - Coccyx: 4.5 X 3.5 X 0.3 cm, Stage II. Current treatment, crusting procedure. The facility failed to document assessments of the

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) resident's right heel wound from 8/9/2020 - 8/24/2020. The lab report dated 5/21/2020 revealed the resident had an [MEDICATION NAME] level of 3.3, with normal range of 3.3 - 4.5/dl. The Physician's After Visit Summary dated 8/24/2020 revealed the physician ordered [MEDICATION NAME] (antibiotic) and made referrals to the Healing Center and ordered an Ultrasound of the right leg. The [DIAGNOSES REDACTED]. Observation on 8/25/2020 revealed the resident seated in his/her room, in a wheel chair without foot pedals and with gripper socks on bilaterally. The resident failed to have blue foam boot on the right foot. Observation on 8/25/2020 at 10:45 A.M. revealed Staff B, Licensed Practical Nurse (LPN) provide treatment to Resident #7's right heel and buttock wounds: a. The right heel wound measured 3.3 X 2.6 cm with eschar (dark scab of dead skin). b. The bilateral buttock wound (coccyx and sacral wound combined), butterfly shaped measured 4.2 X 3.7 X 0.9 cm. c. The wound base appeared red with white edges and the surrounding skin had a red scattered rash. Staff B indicated the rash was new. d. Staff B applied the treatments as the physician ordered. The physician progress notes [REDACTED]. The physician determined the resident had [MEDICAL CONDITION] of the right lower extremity and ordered an antibiotic and an ultrasound of the right leg. The physician also ordered the resident be seen at the wound clinic. The resident had an appointment made for Friday, 8/28/2020 at the wound clinic. During an interview on 8/25/2020 at approximately 1:00 P.M., Staff A, Dietician reported he/she had no knowledge of Resident #7's pressure wounds. Due to Covid-19, he/she could not enter the facility since March and relied on nursing to communicate any concerns regarding residents. Staff A stated unaware Resident #7 had wounds, if he/she had, he/she would have recommended a supplement to assist with wound healing. During an interview on 8/25/2020 at 2 p.m., Staff C, LPN indicated the Dietician emails Staff C along with Staff D, Director of Nursing (DON) weekly and asks if they have any concerns. The Dietician last emailed on 8/12/2020, during the power outage. Staff C reported, LPN's are not allowed to stage wounds, that had to be done by a Registered Nurse (RN). Protein supplements such as pro-stat is documented on the MAR for nurses to administer. During an interview on 8/25/2020 at 9:30 a.m., Staff D, DON reported the resident had an appointment with the physician on 8/25/2020 and the resident's family asked if he/she could start going to the wound clinic. During an interview on 8/25/2020 at approximately 9:15 a.m., Resident #7 reported seeing the doctor yesterday. The doctor did not know they weren't sending him/her to the wound center and they scheduled an appointment. The resident also had another test ordered and he/she also received a new medication but could not recall the name of it. 2. The MDS dated [DATE] revealed Resident #8 with no risk of pressure ulcer/injury risk and no unhealed pressure ulcers/injuries. The MDS dated [DATE] revealed the resident with severe cognitive impairment, transferred from one surface to another with extensive assistance of one staff, required supervision and set up assistance for eating, did no ambulate and had [DIAGNOSES REDACTED]. The MDS documented the resident had one Stage 2 pressure ulcer. The Care Plan identified the resident had potential for nutritional problems related to [DIAGNOSES REDACTED]. It directed the Dietician to evaluate and make diet change recommendations as needed quarterly, annually and as needed. The resident had a potential for impaired skin integrity due to limited mobility related to [MEDICAL CONDITION]. The Care Plan directed staff to monitor/document location, size and treatment of [REDACTED]. Staff were to assist resident with utilizing a pressure reduction boot to right foot at all times, remove during transfers and ambulation. The physician's orders [REDACTED]. Apply moon boots. Staff A, Dietician notes documented the following: a. On 5/18/2020, Staff A recommended pro-stat 1 ounce every day for 30 days for pressure ulcer. b. On 7/8/2020, recommended a house supplement for weight loss in the past 3 months. The Dietician recommended supplement, 60 ml/day for 30 days. c. On 8/12/2020, recommended pro-stat or an equivalent protein supplement, one ounce a day for 30 days. Weight stable. Labs dated 6/15/2020 revealed [MEDICATION NAME] 3.4 and total protein 7.1 g/dl. Skin Assessments included: a. On 5/8/2020 - Right Heel, 2.5 X 1.2 cm, St I, MD notified. b. On 5/20 and 5/22/20- weekly skin assessment. Skin intact. No areas of concern identified. c. On 5/28/2020 - Right Heel, 2.0 X 13.5, Stage I. Dark red wound bed with intact surrounding tissue. Center boggy. MD notified. d. On 6/19/2020 - Right Heel, 2.5 X 2.4 X 0.2 cm. Wound bed pink. 7/3/2020 - Right Heel, Pressure, 1.2 X 1.0 X 0.2 cm. Stage II. White macerated wound edge with normal skin surround. e. On 7/10/2020 - Right Heel, Pressure, 2.4 X 2.4 X 0.4, Stage I. f. On 7/17/2020 Weekly Skin Assessment: Intact skin. g. On 7/17/2020 - Right Heel, 1.25 X 1.0 X 0.1. Stage II h. On 7/24/2020 - Weekly Skin Assessment, skin intact. i. On 7/24/2020 - Right Heel, Pressure, 1.5 X 1.02 X 0.1 j. On 7/31/2020 - Right Heel, Pressure, 1.25 X 0.5 X 0.1 Stage II k. On 8/7/2020 - Right Heel, Pressure 1 X 0.75 X 0.1 State II l. On 8/7/2020 - Weekly Skin Assessment, Skin intact. m. On 8/14/2020 - Nurse's note: Stage II, pink wound bed, 1 X 0.25 X 0.1. [MEDICATION NAME] applied. Observation on 8/25/2020 at approximately 12:15 p.m., revealed Resident #8 seated in the wheel chair facing the bed with a tray table and lunch items. The wheel chair had no foot pedals and the resident wore gripper sox and no blue moon boot. Observation on 8/25/2020 at 2:30 p.m., revealed Staff F, LPN provide wound treatment and assessment for the resident's right heel. The wound measured 1.5 X 1.0 cm. Staff F cleansed the area with normal saline and applied an ointment, border gauze and kling wrap. Staff F indicated the wound appeared to be healing. The wound base appeared red with white edges. Staff F reported sometimes the resident ate the yogurt served as a bedtime snack, about 50 % of the time. Resident #8 reported he/she did not like the yogurt. During an interview on 8/25/2020 at approximately 1:25 p.m., Staff A, Dietician reported he/she recommended pro-stat due to the resident's stage II right heel ulcer. Staff A reported the facility had not yet responded to the recommendation. Staff A indicated there have been recommendations that the facility has failed to follow up with. He/she reviews resident charts weekly, emails Staff C, LPN, Staff D, DON and Staff E, Dietary Staff in the morning and asks if they have any residents with concerns. Staff A usually fails to get a response. At the end of the day, Staff A informs the same staff residents reviewed and recommendations. During an interview on 8/26/2020 at 9:45 a.m., Staff D, DON reported Resident #8 received yogurt due to an issue with [MEDICAL CONDITION]. ([MEDICAL CONDITION], a bacteria). During an interview on 8/26/2020 at 11:05 a.m., Staff D, reported informing Resident #8's physician on 8/24 of the Dietician's recommendation. The resident received Pro-stat in May for 30 days, and did not receive house supplement in July. Staff D reported being aware of the skin assessment and documentation issue and has a Quality Assurance plan in place. Going forward, Staff D plans to do all pressure sore assessments and has a nurses meeting scheduled to provide education regarding proper documentation and weekly assessments where staff is to look at the entire body.