STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165284	A. BUILDING _____ B. WING _____	**04/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNY KNOLL CARE CENTRE	**135 WARNER STREET ROCKWELL CITY, IA 50579**

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

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to assure treatment provided in a manner to preserve dignity for 1 of 2 resident's reviewed (Resident #1). The facility reported a census of 18 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, toilet use, dressing and bathing. The resident had an indwelling urinary catheter. The resident's [DIAGNOSES REDACTED]. During an observation on 4/2/12 at 11:12 a.m. Staff A Licensed Practical Nurse (LPN) performed a dressing change to the resident's right buttock, and provided care of his suprapubic catheter insertion site. The curtain to the outside window remained open during the procedures. During an interview on 4/8/20 at 6:54 p.m. the Director of Nursing stated staff should close the curtains to the window when doing the resident's treatments.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, confidential resident interview, and staff interview the facility failed to assure a homelike environment free of odors. The facility reported a census of 18 residents. Findings include: On entrance to the building on 4/2/20 at 8:50 a.m. a urine odor was immediately noted. The odor was noticeable throughout the halls, and more prominent on the 200 hall. During a confidential resident interview on 4/2/10 at 1:10 p.m. Resident #5 stated the facility had a urine or ammonia smell most of the time, and it was unpleasant. During a confidential resident interview on 4/2/10 at 1:15 p.m. Resident #6 stated the urine odor got real bad at times and the facility always smelled. During a confidential resident interview on 4/2/10 at 1:22 p.m. Resident #7 stated it always smelled like urine or feces, and it was terrible. During an interview on 4/7/20 at 9:02 a.m. the Director of Nursing stated they had complaints about odor in the facility. She said they were working very hard at sanitizing. She said they cleaned the carpet in 1 room with odor. She was not aware of any grievances filed, but may residents and families complained about odor, and they could smell it themselves.
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, record review, and staff interview, the facility failed to complete accurate documentation and failed to provide a treatment order for 1 of 4 resident's reviewed (Resident #2). The facility reported a census of 18 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, toilet use, dressing and bathing. The resident demonstrated bowel and bladder incontinence. The resident's [DIAGNOSES REDACTED]. The current Care Plan revised 3/21/20 identified the resident with open areas to the posterior bilateral thighs. The interventions included administering treatments as ordered and monitoring for effectiveness. The Treatment Administration Record (TAR) for March 2020 identified a discontinued physician order [REDACTED]. [MED] (barrier) daily and as needed (PRN), discontinued 3/31/20. The TAR showed a new order for cleaning legs with soap and water and applying triple antibiotic ointment (TAO) to open areas every day and night shift for wound care, ordered 3/31/20. The clinical record lacked the order for the treatment change on 3/31/20. During an observation on 4/2/20 at 2:20 p.m. Staff A Licensed Practical Nurse (LPN) performed treatment to the resident's lower legs. Staff A used foam wash to the right leg, wiped off it with ABD pads, cleansed with normal saline and ABD pads, and applied [MED] (antibiotic) to intact skin and placed an [MED] (absorbent polymer) dressing to the open area. The TAR for April 2020 showed Staff A checked and initialed completing the order for cleaning legs with soap and water and applying triple antibiotic ointment (TAO) to the open areas. During an interview on 4/6/20 at 1:12 p.m. Staff A stated when she talked to the resident prior to doing the treatment she didn't want the new treatment. She confirmed she did initial the new treatment completed in error. She also stated she did not complete the treatment on Saturday or Sunday either, but she initialed it as completed. During an interview on 4/7/20 at 8:54 a.m. the Director of Nursing stated she expected staff to follow wound orders and if not able, to notify the provider. She stated the resident's orders changed 3/31/20 after she sent an update to the provider with the resident's wound status. At the time of exit 4/9/20 at 1 p.m. the facility could not locate the 3/31/20 order for the treatment change.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to assure residents received 2 baths per week for 4 of 4 residents reviewed (Resident #1, #2, #3, and #4). The facility reported a census of 18 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, toilet use, dressing and bathing. The resident had an indwelling urinary catheter. The resident's [DIAGNOSES REDACTED]. The current Care Plan revised 8/5/18 identified the resident with an ADL self care performance deficit related to activity intolerance, [MEDICAL CONDITION], and deconditioning. The care plan lacked interventions related to bathing. The facility bath records lacked documentation the resident received a bath between: a. 2/6 and 2/13/20, b. 2/13 and 2/20/20, c. 2/27 and 3/5/20, d. 3/9 and 3/16/20, e. 3/16 and 3/23/20. 2. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, toilet use, dressing and bathing. The resident demonstrated bowel and bladder incontinence. The resident's [DIAGNOSES REDACTED]. The current Care Plan revised 9/14/19 identified the resident with an ADL self care performance deficit related to activity intolerance, disease process, limited mobility, and pain. The interventions included the resident required assist of 2 for bathing, she did not get up for baths and had bed baths with the tendency to refuse. The resident totally depended on staff to provide a bed bath twice a week and as necessary. The facility bath

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) records documented the resident received 1 bath in February, no baths in March, and 1 bath in April 2020 through the 7th, with 1 refusal. 3. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #3 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident depended on staff for bathing. The resident had an indwelling urinary catheter and had bowel incontinence. The resident's [DIAGNOSES REDACTED]. The current Care Plan revised 1/7/20 identified the resident had an ADL self care performance deficit related to amputation of the left leg below the knee and weakness. Interventions included the resident bedfast all or most of the time related to her choice of not wanting to get out of bed, up for shower with total mechanical lift. The facility bath records documented the resident received only 5 baths in February, and 4 baths in March 2020. 4. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #4 demonstrated long and short term memory impairment and moderately impaired skills for daily decision making The resident required extensive assist with bathing. The resident had bowel and bladder incontinence. The resident's [DIAGNOSES REDACTED]. The current Care Plan revised 4/1/17 identified the resident with an ADL self care performance deficit related to a history of [MEDICAL CONDITION], arthritis, dementia, fatigue and limited mobility. The interventions included the resident required 1 staff participation with bathing. The facility bath records lacked documentation the resident received a bath between: a. 2/5 and 2/12/20 (7 days), b. 3/4 and 3/16/20 (12 days), c. 3/16 and 3/25/20 (10 days). During an interview on 4/2/20 at 1:50 p.m. Staff C Certified Nursing Assistant (CNA) stated they had only 2 aides and they did not have time to do baths. During an interview on 4/8/20 at 9:55 a.m. the Administrator stated residents should receive 2 baths per week unless care planned otherwise.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for a change in condition for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 18 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, toilet use, dressing and personal hygiene. The resident had an indwelling urinary catheter. The resident's [DIAGNOSES REDACTED]. The current Care Plan with a goal target date of 6/15/20 identified the resident had potential fluid deficit related to poor intake. The interventions included monitoring vital signs as ordered/per protocol and record, and notify the physician of significant abnormalities, initiated 11/7/19. The Progress Notes dated 12/6/19 at 5:51 p.m. documented another resident asked the nurse to check on the resident in his room due not feeling well. The resident sat in his wheelchair with his shirt open, sweating in his face and chest. The resident stated he felt hot and did not like it. The nurse got a cold wash cloth, patted his head, neck and chest, and the resident stated that made him feel better. The nurse opened his window a little as the facility felt slightly extra warm. The resident's Temperature 98.0, Pulse 166, Respirations 20, Blood Pressure 130/78, and Oxygen saturation 93% on room air. Lung sounds assessed clear in all lung fields, and the resident denied shortness of breath, issues swallowing, chest pain or discomfort at the time. The resident's apical pulse per auscultation 170 (normal 60-100). The resident's pulse tended to run high at times. The resident stated he felt fine, just hot, and reported all above information to the charge nurse. The clinical record lacked follow up of the resident's condition. The Progress Notes dated 12/7/19 at 3:23 a.m. documented a fall with staff finding the resident laying on his right side with right arm straight out under his head and legs contracted per usual and no deformities noted. The resident could not tell the nurse what happened, stating he got up and went down. The nurse asked the resident if he remembered he needed staff and a mechanical lift for transfers. Resident stated he did but he just got up and down he went. Staff observed bladder distention and the supra pubic catheter in his brief, with 100 cc in the tubing and down drain bag. Progress Notes dated 12/7/19 at 3:25 a.m. documented the Registered Nurse (RN) notified the doctor on call and received the okay to send to the emergency room (ER) for evaluation and treatment. The resident transferred by ambulance at 3:44 a.m. At 4:07 a.m. the vital signs documented at Temperature 98.0, Pulse 123, Respirations 18 BP 85/50 (low blood pressure 90/60 or lower). At 5:14 a.m. the ER called reporting the resident had incontinence of a large amount of urine on arrival and would return to the facility. The facility to notify the physician that inserted the supra pubic foley on Monday to have it replaced since the resident could urinate. At 5:57 a.m. the resident returned via ambulance without incident. Neuro's initiated. No delay of injury noted. At 8:21 a.m. the resident laid on the floor between the bed and the wheelchair with no injuries noted. The resident had cold/clammy skin, unstable vital signs and lethargy. The facility placed a call to the ER and ambulance. At 2:26 p.m. hospital staff stated the resident admitted to the hospital with [REDACTED]. They would try to insert a catheter for urinary analysis (UA). Emergency Department Lab Results dated 12/7/19 showed the resident had a white blood cell count of 23.19 (reference range of 5-10) and a CRP of 16.6 (reference range of 0.05-0.6). An Emergency Department Course note dated 12/7/20 documented the resident received a 1 liter bolus of normal saline with significant improvement in his weakness and lethargy, and his pulse improved, he had [MEDICAL CONDITION] 130. Another 1 liter bolus of normal saline was administered. A Hospital Progress Note dated 12/8/19 at 10:49 p.m. documented the resident with no complaints of confusion or lethargy. The resident felt much better, 2 liters of normal saline normalized his heart rate. He started on antibiotics for probable Urinary tract infection [MEDICAL CONDITION]. His WBC significantly improved. The assessment included UTI associated with catheter, leukocytosis (high WBC count), and [MEDICAL CONDITION] The resident's heart rate now normal in the 90's. During an interview on 4/7/20 at 8:25 a.m. the Director of Nursing (DON) stated a pulse of 170 would not be acceptable and they should follow up and notify the provider. During an interview on 4/8/20 at 8:52 a.m. the Advanced Registered Nurse Practitioner (ARNP) stated she expected the facility to notify her of vital signs that exceeded normal. She stated the resident's pulse did run a little high, but 160 and 170 was quite [MEDICAL CONDITION]. She said if the facility notified her, when they initially identified his pulse at 166 on 12/6/19, she would have gone to the facility and checked the resident. She didn't know if it would have prevented the hospitalization , it may not have been preventable at that point. She said the laboratory blood work [MEDICAL CONDITION].
F 0686 **Level of harm** - Minimal harm or potential for 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, record review and staff interview the facility failed to assure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 resident reviewed (Resident #1). The facility reported a census of 18 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, toilet use, dressing and bathing. The resident had an indwelling urinary catheter. The resident's [DIAGNOSES REDACTED]. The care plan initiated 11/7/19 and revised 3/11/20 identified the resident with a pressure ulcer to the right gluteus with surgical debridement done 2/20/20. Interventions included: Assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document status of the wound perimeter, wound bed and healing process. Follow facility policies/procedures for the prevention/treatment of [REDACTED].) x 5 cm. with a pinpoint reddened area near the center of the red rashy area. The reddened skin was blanchable with a 0.9 x 1.1 cm intact, clear fluid filled blister. The resident denied pain and itch. Staff measured the area and cleansed it with mild soap and water. They applied skin prep to the blistered area. The facility requested an order for [REDACTED]. A fax prepared by facility staff and dated 1/3/20 notified the Advanced Registered Nurse (ARNP) of the resident's wounds. The facility informed the ARNP per fax that it did not appear the resident needed a wound center appointment at that time. The fax asked if staff could apply skin prep to the blistered area BID until healed and indicated if the area opened/popped, they would update the ARNP and request an order change. On 1/17/20 a note documented the ARNP did not addressed the fax. A Non Pressure Weekly Skin Record dated 1/3/20 documented the resident with a 0.9 by 1.1 cm intact blister to the sacrum. Per the facility Pressure Injury Weekly Assessment a stage 2 pressure ulcer may present as an intact or open/ruptured serum-filled blister. Progress Notes dated 1/5/20 at 2:57 p.m. documented the area remained on the right buttock and appeared red with no increased warmth. Progress Notes identified the skin at the site as blanchable and surrounding skin within normal limits (WNL). The blister near the coccyx popped with no drainage noted. Staff documented they would continue to monitor. The clinical record lacked ARNP notification of the

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) blister opening or any follow up of the area. Wound Center notes dated 1/28/20 documented a stage 3 pressure ulcer to the midline coccyx measuring 0.4 by 0.8 by 0.2 cm. The wound contained a small amount of serous drainage, with pink granulation, and necrotic tissue within the wound bed, including eschar and adherent slough. Progress Notes dated 1/28/20 at 5:54 p.m. documented the Wound Center would see the resident in a week to recheck his right hip et midline coccyx, and change the dressing daily. Cleanse the pressure ulcer with normal saline (NS) prior to applying a clean dressing using gauze sponges. Do not scrub or use force, pat dry using gauze sponges, or soap and water then apply a thin layer of [MED] (enzymatic [MEDICATION NAME] ointment) to wound bed and cover with [MEDICATION NAME] Border (foam dressing) to coccyx. A wound center note dated [DATE]20 identified the resident with an unstageable pressure ulcer of the sacral region measuring 0.5 cm. by 0.8 cm. by 0.2 cm. The are contained a large amount of necrotic tissue with serous amber exudate. A wound center noted 2/27/2020 revealed the sacral ulcer healed, surgical closure. During an interview on 4/7/20 at 8:25 a.m. the Director of Nursing (DON) stated she did not know about the sacral blister or follow up documentation. She said she completed follow up wound assessments on a weekly basis and if she was gone, someone else needed to complete them. Right buttock: Progress Notes dated 1/9/20 at 12:02 a.m. documented the resident continued with a reddened area to the buttocks. Assessment revealed no foul odor, purulent drainage or signs and symptoms of infection noted. The resident voiced no complaints of pain or itch to the area. The surrounding skin appeared pink and blanchable. Progress Notes dated 1/14/20 at 7:44 p.m. documented the ARNP made rounds with no new orders received. The ARNP directed staff to contact the clinic if redness persisted or the reddened area to his bottom worsened. Progress Notes dated 1/16/20 at 10:42 a.m. documented the area to the right hip/buttock measured 12 cm x 7 cm, and felt very warm to the touch. The resident denied pain but had decreased sensation. Assessment revealed the area firm and blanchable in some spots and boggy in others, with no drainage noted. The resident had a history of [REDACTED]. A Nursing Home Physical Examination dated 1/16/20 documented an acute visit related to a concern with the resident's right buttock. The assessment identified the resident with a stage 2 pressure ulcer, and orders to treat the area included: [MEDICATION NAME] (antibiotic) to the area after cleansing with NS and covering with PolyMem dressing 2 times a day. PolyMem is a multifunctional polymeric membrane dressing comprised of a [MEDICATION NAME] matrix that contains a mild, non-toxic wound cleanser. Progress Notes dated 1/18/20 at 9:57 a.m. documented the hip remained red, with yellow-brown drainage, and foul smell. Staff cleansed the area with wound spray, patted it dry and applied non-adherent foam padding placed and secured with tape. Progress Notes dated 1/19/20 at 9:48 a.m. documented the hip remained red, with yellow-brown drainage, and foul smell. Staff cleansed the area with wound spray, patted it dry and applied non-adherent foam padding placed and secured with tape. Progress Notes dated 1/21/20 at 1:24 p.m. documented the area to the right hip measured 7.5 cm x 6 cm. Assessment revealed copious amounts of yellow/brown drainage on the soiled dressing with no active drainage noted with cleansing of the site. Staff noted some superficial skin peeling with cleansing. The area no longer appeared indurated and contained dark red/brown coloring at the skin site. The area did not blanch. The MAR for January 2010 showed the physician order [REDACTED]. On 4/8/20 at 10:15 a.m. the Director of Nursing (DON) revealed staff did not initiate the treatment ordered 1/16/20 because the nurse over looked it. On 4/8/20 at 8:52 a.m. the ARNP stated she looked at the resident's buttock on on 1/16/20 and wrote orders. She called the wound center for a treatment recommendation until the wound center could evaluate the area. She did not know of the delayed treatment. She expected staff to begin the treatment right away. On [DATE] the Wound Center identified the right gluteus pressure sore measured 12.4 cm. by 7.5 cm. by 0.1 cm. the area was unstageable and contained a large amount of necrotic tissue . The orders included Dakin's (strong antiseptic that kills most forms of bacteria [MEDICAL CONDITION]) wet to dry packing in the right buttock wound. The Treatment Administration Record (TAR) for February 2010 revealed staff did not begin the [DATE] wound center orders to cleanse the right gluteus with normal saline, pat dry and pack with Dakin's moistened gauze until 2/10/20 (4 days after the order). Progress Notes dated [DATE] at 9:13 p.m. documented awaiting arrival of Dakin's Solution for right gluteus pressure ulcer treatment. Progress Notes dated 2/7/20 at 7:54 a.m. documented Dakin's solution on order so staff applied ointment. Progress Notes dated [DATE] at 8:13 a.m. documented Dakin's solution on order awaiting insurance to cover. The DON aware. Progress Notes dated 2/9/20 at 8:38 a.m. documented Dakin's solution on order. Pharmacies and DON aware Progress Notes dated 2/10/20 at 8:15 a.m. documented Dakin's solution on order and awaiting delivery. Hospital notes dated 2/20/2020 identified the resident with a Stage 4 right gluteal pressure ulcer which was the reason for the hospital admission. The subjective section of the hospital report revealed the resident returned to the wound center with a significant pressure ulcer of the right buttock that got worse. On 2/20/2020 the wound appeared quite necrotic with surrounding cellulitic changes. Due to the severity of the wound, the resident required operating room debridement and admission to the hospital for antibiotics and wound care. According to hospital reports, the resident returned to the facility 2/25/2020. Wound center notes dated 3/5/2020 identified the area as an open surgical wound measuring 15 cm. by 7 cm. by 2.5 cm. containing yellow brown green purulent drainage. The wound was full thickness with exposed support structures. A pressure injury weekly assessment identified the Stage 4 right buttock pressure sore to measure 15 cm. by 7 cm. by 2 cm. On 4/8/20 at 10:05 a.m. the DON stated the pharmacy did not have Dakin's on hand, and had to order it. She didn't know if anyone called the wound center and ask for recommendations while they waited for Dakins solution to arrive. On 4/8/20 at 2:49 p.m. the Wound Center Nurse stated if the facility could not get the Dakins solution right away and called asking for recommendations, that the Wound Center could have provided a simple recipe for Dakin's consisting of water and bleach. Left ischial: . Wound Center notes dated 2/10/20 identified the resident's left ischial area measuring 1.3 by 0.8 by 0.2 cm. and a stage 3 pressure ulcer. New orders included to cleanse with normal saline, apply a thin layer of Santyl and cover with [MEDICATION NAME] (foam dressing) border. Wound Center notes dated 2/27/20 documented the left ischial ulcer measured 0.7 by 0.2 by 0.1 cm. After debridement the wound measured 0.7 by 0.2 by 0.2 cm. The new order consisted of [MEDICATION NAME] (antibiotic) and [MEDICATION NAME] Border. Wound Center notes dated 3/5/20 documented the ischial ulcer measured 0.7 by 0.2 by 0.1 cm. After debridement the wound measured 0.7 by 0.2 by 0.2 cm. The order remained the same. The Progress Notes dated [DATE] at 11:12 a.m. documented the wound to the left ischium closed, no area observed. The Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The remaining days of the month lacked initials. Wound Center notes dated 3/12/20 documented the left ischium ulcer as a Stage 3 measuring 0.5 by 0.2 by 0.1 cm. After debridement the area measured 0.5 by 0.2 by 0.3 cm. The order for treatment remained the same. The clinical record lacked documentation the facility completed the ischial treatment as ordered. The clinical record lacked assessment of the ulcer of the ischium from the last wound center note 3/12/20 when the Stage 3 area measured o.5 cm. by 0.2 cm. by 0.1 cm. until 3/30/20. A pressure injury weekly assessment dated [DATE] identified the area as a Stage 3 measuring 0.2 cm. by 0.2 cm. by 0.1 cm. During an observation on 4/2/20 at 11:12 a.m. Staff A Licensed Practical Nurse (LPN) prepared to do treatments. Staff A completed treatments to the right buttock and suprapubic catheter insertion site. Staff A stated the resident had no other areas to treat. During an interview on 4/6/20 at 1:12 p.m. Staff A confirmed she did not do the treatment to the ulcer of the ischium. She said she missed it. She said she saw it when she worked the past weekend. During an interview on 4/7/20 at 8:25 a.m. the DON stated she had investigated and found that someone had discontinued the treatment on 3/11/20. She also found on the last wound center visit (3/12/20) the resident still had an ulcer and the treatment should have continued. She said when the order discontinued it would not show on the MAR for completion. She didn't know if the resident received treatment during that time. She said she corrected it on the [DATE]/3/20 and then it showed for completion. She confirmed the resident continued with a stage 3 ulcer of the left ischium. During an interview on 4/7/20 Staff B LPN stated she had been back at the facility for about 2 weeks. She stated she had not previously been doing the treatment to the resident's ischial ulcer, but she did it on this day.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to provide appropriate care of a catheter for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 18 residents. Findings include: A Minimum Data Set ((MDS) dated [DATE], assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, toilet use, dressing and bathing. The resident had an indwelling urinary catheter. The resident's [DIAGNOSES REDACTED]. The current Care Plan revised 11/7/19 identified the resident with an indwelling catheter due to [MEDICAL CONDITION] bladder. The interventions included monitoring/recording/reporting to the physician as needed (PRN)

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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 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) signs/symptoms of urinary tract infection [MEDICAL CONDITION]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. During an observation on 4/2/12 at 11:12 a.m. Staff A Licensed Practical Nurse (LPN) prepared to do treatments. She laid the bed flat, then moved the bed away from the wall stepping on the mat beside the bed. The resident's catheter tubing rested on the bedside mat with visible debris on the mat. During an observation on 4/2/20 at 12:57 p.m. Staff D Certified Nursing Assistant (CNA) and Staff D CNA transferred the resident from the bed to the wheelchair via the total mechanical lift. When transferred to the chair, the resident's catheter bag touched the floor while hanging from under the wheelchair. The resident moved the wheelchair per self with the bag dragging on the floor. At 4 p.m. the resident laid in bed with the catheter bag on the floor. During an interview on 4/2/20 at 4 p.m. the Director of Nursing stated she expected the catheter bag and tubing to remain off the floor or the mat. The Healthcare Infection Control Practices Advisory Committee, Guideline For Prevention of Catheter Associated Urinary Tract Infections 2009, updated 6/6/19 documented the proper techniques for urinary catheter maintenance included keeping the collection bag below the level of the bladder at all times, and not resting the bag on the floor.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to implement appropriate infection control procedures during wound care for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 18 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, toilet use dressing and bathing. The resident had an indwelling urinary catheter. The resident's [DIAGNOSES REDACTED]. During an observation on 4/2/12 at 11:12 a.m. Staff A Licensed Practical Nurse (LPN) prepared to do treatments. She laid the bed flat, and put supplies on the bedside stand with no barrier. She washed her hands and donned gloves. Staff A removed the dressing to the right buttock and changed gloves with no hand hygiene. Staff A placed a bottle of wound cleanser and Dakin's (strong antiseptic that kills most forms of bacteria [MEDICAL CONDITION]) solution directly on the resident's bed. She cleansed the wound and applied Dakin's to gauze and placed the gauze in the wound. She placed a bottle of hand sanitizer on the resident's bed. She changed gloves with hand hygiene and cleansed the resident's suprapubic catheter site. The hand sanitizer and wound cleanser laid on the bed at the resident's feet. Staff A sat the wound cleanser on the floor with no barrier and put the hand sanitizer in her pocket. Staff A performed hand hygiene, picked the wound cleanser up of the floor and walked to the treatment cart where she sat the wound cleanser bottle. During an interview on 4/8/20 at 6:54 p.m. the Director of Nursing (DON) stated she expected staff to place a barrier between supplies and the resident's personal space, and not place supplies on the floor to avoid cross contamination.