STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	**1037 19TH STREET SW MASON CITY, IA 50401**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a clean environment. The facility reported a census of 74. Findings include: On 8/21/20 at 7:05 AM, Staff F, Certified Nurses' Aide (CNA), said the housekeepers don't clean things. There were stains on the curtains and the floor that housekeeping doesn't clean. On 8/24/20 at 4:41 PM, observed in room [ROOM NUMBER], dark brown liquid drips ranging in size going down the wall, dried to the wall, on the south side of the door. On 8/25/20 at 1:18 PM, the dark brown drips remain on the wall on the south side of the door in room [ROOM NUMBER]. On 8/26/20 at 1:50 PM, observed a softball-sized dark brown area on the carpet in room [ROOM NUMBER] just north of the bathroom door. On 8/26/20 at 2:30 PM, the Administrator reported that the facility cleaned it right away if notified of something. The Administrator knew of a couple of instances with needing curtains changed. The Administrator said they counted on the staff to let the housekeeping or administrative staff know if there was a concern. The staff is to report. If the staff see something, they can clean it. Not my job mentality should not exist. The Housekeeping Supervisor just shampooed carpets in Southern Breeze as they were original to the facility. These carpets will be changed out when the facility is allowed to reopen.
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 interviews, record reviews, and observations, the facility failed to complete a comprehensive care plan to accurately reflect the care required for a resident with a pressure ulcer for one of four resident's reviewed (Resident #2). The facility reported a census of 74. Findings include: The Minimum Data Set (MDS) completed for Resident #2 with an Assessment Reference Date (ARD) of 8/13/20 showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident admitted on [DATE] with a stage IV pressure ulcer. The resident required pressure ulcer care. The resident had a pressure-relieving device in the bed and chair. The resident required extensive assistance of one staff with bed mobility, dressing, transfers, and toileting during the seven day lookback period. The resident exhibited no instances of rejection of care during the seven day lookback period. The resident showed verbal and other behaviors for one to three days in the last seven days in the lookback period. The resident used opioids for seven of seven days of the lookback period. The resident was always incontinent of bowel and bladder in the seven day lookback period. The resident had [DIAGNOSES REDACTED]. Record review The History and Physical dated 1/3/20 showed the resident admitted to the hospital in 11/19 due to a deep lumbar-sacral ulcer due to suspected osteo[DIAGNOSES REDACTED]. The imaging was inconclusive on diagnosing osteo[DIAGNOSES REDACTED]. The resident did require a course of [MEDICATION NAME] for weeks. The COMS - Skilled Evaluation - V 5.1 assessment dated [DATE] showed the resident was concerned with a pressure ulcer on the coccyx. On 2/25/20, the Doctor's Orders and Progress Notes showed an order for [REDACTED]. The resident's baseline weight was approximately 180 pounds in 3/19. A Care Plan problem dated 8/12/20 showed the resident had a sacral pressure ulcer related to immobility due to MS. The problem showed the following interventions dated 8/12/20 1. Administer treatments as ordered and monitor for effectiveness. 2. Assess, record, and monitor wound healing (specify frequency FREQ). Measure length, width, and depth where possible. Assess and document the status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the Medical Doctor (MD). 3. Educate the resident, family, and caregivers as to causes of skin breakdown, including transfer and positioning requirements; the importance of taking care during ambulating, mobility, good nutrition, and frequent repositioning. 4. The resident had a [DEVICE] to the wound on the resident's sacral area but requested it removed. The resident had an indwelling catheter to help with wound healing but asked for discontinuation. The resident, at times, refused to have the ordered treatment to wound completed. Staff will re-approach at another time or have another staff to complete the dressing change. 5. The resident required an air loss mattress on the bed and pressure reduction cushion in the wheelchair. 6. The resident needed the bed to be positioned to reduce the possibility of shear. The resident preferred to be repositioned with two people and a draw sheet. 7. If the resident refused treatment, confer with the resident, Interdisciplinary Team (IDT), and family to determine why and try alternative methods to gain compliance. Document alternative methods. 8. Inform the resident, family, and caregivers of any new area of skin breakdown. 9. Monitor nutritional status. Serve diet as ordered, monitor, and record intake. 10. Monitor, document, report as needed (PRN) any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), and stage. The Care Plan lacked interventions related to pressure ulcers before 8/12/20. During observation on 8/25/20 at 3:50 PM, observed Staff A, Licensed Practical Nurse (LPN), provide pressure ulcer care to the resident's coccyx. No dressing was seen to the area at the start of the treatment. During interview on 8/26/20, at 1:20 PM, the Director of Nursing (DON) said they expected interventions related to pressure ulcers to be care planned.
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 observations, interviews, and record reviews, the facility failed to get the equipment required for a resident to prevent the resident's decline for one resident reviewed (Resident #4). Based on interviews and record reviews, the facility failed to get orders within an appropriate time frame for one resident reviewed (Resident #3). The facility reported a census of 74. Findings include: 1. The Minimum Data Set (MDS) completed for Resident #4 with an Assessment Reference Date (ARD) of 6/25/20 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was independent without an assistive device for bed mobility, transfers, walking in the room, and eating.The resident required supervision with personal hygiene, toileting, locomotion off the unit, and walking in the corridor. The resident had no impairments with the upper or lower extremities. The resident took a diuretic and an anticoagulant for seven of seven days in the lookback period. The resident had [DIAGNOSES REDACTED]. Interviews On 8/24/20 at 7:11 AM, Staff F, Certified Nurses' Aide (CNA), said there was a concern with the resident for over a month. The resident had runs that turned into a huge hole in the compression stockings. The hole became so big the resident couldn't wear the compression stockings. The nurses were notified of this. Due to the compression stocking hole, the resident's right leg went without a compression stocking. The resident woke up, one-night complaining of pain and swelling. The resident then required more staff assistance. The facility took the resident to the Doctor to make sure it wasn't broken or had a blood clot (Deep vein [MEDICAL CONDITIONS]). The resident now required their legs to be wrapped. Staff F asked the nurse if the need for the

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
	165536	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	1037 19TH STREET SW MASON CITY, IA 50401

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident to have their legs wrapped was due to not having their compression stockings for well over a month. The resident has serious issues with their heart and legs. Staff F said they would have thought someone would do something sooner. Staff F did voice concerns about this to other nurses. On 8/24/20 at 1:07 PM, Staff E, CNA, said they knew the resident's compression stocking was missing but was unsure how long. The resident needed the staff's help with removing the compression stockings at night. On 8/24/20 at 1:34 PM, the Resident's Representative said the resident's care was good most of the time. The Resident's Representative said the resident had an order for [REDACTED]. The Resident's Representative said whoever was supposed to measure for the stockings did not measure the resident. The Resident's Representative reported they were never told that the resident needed new Juzo stockings, or they would have got her new ones. The Resident's Representative thought this was around July 31st at their first courtyard visit. The resident had two Representatives at the first courtyard visit. The resident told them the facility was getting them new ones. The Resident's Representative said the resident was sent to the hospital due to not having their stockings. The facility thought the resident had a blood clot or a fracture. The resident went from independent with cares to needing staff assistance within days. The Resident's Representative felt it was 95 percent (%) positive that the need to go to the hospital was due to not having the resident's Juzo stockings. The Resident's Representative said they are unsure if things were being reported or followed up on if reported. The Resident's Representative said if [MEDICAL CONDITION] didn't happen, they would've seen it, and the resident would have gotten new stockings sooner. Due to the resident needing to go to the hospital, the resident was then required to go in isolation. The Resident's Representative wondered who would help their resident when they weren't around. The Resident's Representative said they did report this to the Director of Nursing (DON). On 8/24/20 at 3:15 PM, Staff C, Licensed Practical Nurse (LPN), said the resident's compression stockings were missing for a couple of weeks, and the one compression stocking was ripped for two to three weeks. Staff C said they were unaware of how long the resident was without compression stockings before it was reported. On 8/26/20 at 12:45 PM, Resident #4 said that the staff was nice. The resident denied pain stating it was due to the wraps on her legs that helped with the swelling in her legs. Observation On 8/26/20 at 12:45 PM, noted the resident was sitting in a wheelchair in the living room area of Rosewood Court. The resident showed the legs wrapped in [MEDICAL CONDITION] wraps. Record review The Medication Review Report dated 5/22/20 showed the resident was to wear Juzo socks on in the morning and take off in the evening twice a daily for [MEDICAL CONDITION] with an order date of 8/3/18. The Orders - Administration Note dated 7/14/20 at 6:42 AM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to one stocking having a hole in it. The resident needed new ones. The Orders - Administration Note dated 7/19/20 at 6:57 AM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to one stocking was missing. A note was left on the daily log. The Physician Visit note dated 8/07/20 at 10:15 AM, labeled as a late entry, showed two Medical Doctors (MD) visiting with the resident, via telehealth, related to the resident's 60-day recertification. The exam was unremarkable, with no new orders at the time. The Health Status Note 8/09/20 at 9:42 AM explained a note left on a daily log regarding new Juzos stockings. The Incident Note dated 8/11/20 at 6:43 AM showed the resident complaining of right ankle pain. The resident expressed she got up to go to the bathroom, and the resident's ankle felt funny. The resident said it was hard to walk. The resident expressed it was very painful and rated the pain 6 to 7 on a scale of one to 10. The ankle was swollen with [MEDICAL CONDITION], warm to the touch. The nurse planned to fax the Doctor. The resident's representative notified and said to wait a few hours and see if the resident was still complaining. The COMMUNICATION - with Family note dated 8/11/20 at 6:48 AM indicated the nurse spoke with the Resident's Representative and informed them the resident complained of right ankle pain. The ankle was swollen with [MEDICAL CONDITION] and painful. The Resident's Representative said to give the resident some Tylenol. Then give it a few hours and see if they were still in pain. The nurse would continue to monitor. The COMMUNICATION - with Family dated 8/11/20 at 12:03 PM explained the Resident's Representative contacted related to the resident's right ankle pain. When assessed by the nurse, the ankle had plus (+) three non-[MEDICAL CONDITION], cool to the touch, with the resident denying any pain. The nurse had spoken with OT to screen the resident tomorrow to evaluate for new compression stockings for the right leg. The screening tool was filled out. The nurse also asked Staff S, Certified Medication Aide (CMA), and Staff T, CNA, to elevate the resident's foot after lunch, continue with as needed (PRN) [MEDICATION NAME], and apply a cool pack, per nursing judgment, PRN, to assist with swelling and pain. The Resident's Representative verbalized understanding and agreed. The Orders - Administration Note dated 8/12/20 at 1:53 PM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed as the resident was missing one compression stocking. Orders were faxed to the Doctor about getting new compression stockings and checking to ensure the resident did not have a [MEDICAL CONDITION]. The Health Status Note dated 8/13/20 at 4:22 PM showed the resident continued to have 3+ pedal [MEDICAL CONDITION] with no increased warmth. The resident complained of pain with a homans test. Awaiting to hear back from the Doctor regarding the matter. A report will be given to 6:00 AM to 2:00 PM nurse to follow-up with the resident and ensure the right leg's evaluation. The resident denied shortness of breath. The Orders - Administration Note dated 8/13/20 at 1:31 PM indicated that the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to the left leg due to increased swelling and pain. The Orders - Administration Note dated 8/14/20 at 7:43 AM indicated that the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was on the left lower extremity. The Health Status Note dated 8/14/20 at 9:22 AM said the right foot was assessed that AM. The staff reported the resident required the assistance of two staff for transfers. The wheelchair was used for transportation-4+ [MEDICAL CONDITION] to top of the resident's right foot. The left leg is per the resident's usual. The resident stated they were unable to move the foot up and down. The resident said they had sharp pain when putting pressure on it. The Doctor was paged and returned the phone call. The findings discussed, and the Doctor would like to see the resident in the office with x-rays at 10:30 AM. The Appointments Note dated 8/14/20 at 10:15 AM, explained the resident left the facility via the facility van for an appointment with the Doctor. A copy of the Medication Administration Record [REDACTED]. The COMMUNICATION-with Physician dated 8/14/20 at 12:11 PM indicated a return fax was received from the Dr. with an order for [REDACTED]. The Appointments Note dated 8/14/20 at 12:14 PM showed the resident returned from the appointment with the Doctor. The resident said they don't know what is wrong with the foot. The resident had an appointment card for a telehealth appointment with the Doctor on 8/21/20 at 9:30 AM. The resident moved to room [ROOM NUMBER] for fourteen days, quarantine at the time of return. The driver said the Doctor would fax new orders; none received at that time. The COMMUNICATION-with Physician Note dated 8/14/20 at 1:40 PM ,indicated a voice message left for OT regarding the order for an evaluation and treatment. The Patient Screen Form signed by the Physician on 8/14/20 showed the resident required a referral due to swelling of an extremity, pain, and a limp or unsteady walk. The form indicated that nursing supported the screen. The Physician recommended OT to evaluate and treat to rule out a [MEDICAL CONDITION] before completing the OT orders. The Health Status Note dated 8/14/20 at 7:39 PM stated the resident remained in their room on isolation precautions due to leaving the facility for their doctor appointment. No new orders were received from that Doctor's appointment. The resident expressed they had no broken bones in their foot and didn't know what was causing the pain and swelling. The Health Status Note dated 8/15/20 at 5:09 AM said the resident was very determined to be self-care, but the resident did need staff assistance as the right leg was still causing pain. The right leg had 3+ [MEDICAL CONDITION] and was warm to the touch. The resident required to keep the leg elevated and no weight-bearing. The resident was encouraged to ask for staff assistance. The Health Status Note dated 8/15/20 at 1:45 PM indicated a follow up to right foot discomfort. The resident stated their foot still hurt but was a little better. The resident rated their pain five on a one to 10 pain scale with PRN Tylenol given that shift. The resident pivot transferred with the assistance of one staff that shift. The resident was in good spirits and stated they liked their room. The Orders - Administration Note dated 8/15/20 at 1:46 PM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to right foot discomfort. The Health Status Note dated 8/16/20 at 5:18 AM stated the resident maintained their isolation that shift, with no pain complaints. The resident was very careful and transferred with one staff's assistance to not bear weight on the right foot and leg. The right foot and leg showed [MEDICAL CONDITION] 2+ this AM. The Health Status Note dated 8/16/20 at 2:02 PM indicated the resident continued isolation following an off-site visit. The resident stated they were still having right foot discomfort. The resident said they would take some Tylenol later that day; however, the resident declined at the time. The resident continued to use a wheelchair for transport to and from the bathroom. The right foot was pink with 2+ [MEDICAL CONDITION]. The resident refused the compression sock. The Health Status Note dated 8/16/20 at 7:21 PM indicated the resident continued isolation following an off-site visit. The resident had a right foot discomfort and [MEDICAL CONDITION]. The resident was offered Tylenol for pain and discomfort. The resident continued to use a wheelchair for transport to and from the bathroom. The right foot appeared

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	**1037 19TH STREET SW MASON CITY, IA 50401**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) to have 2+ [MEDICAL CONDITION]. The Orders - Administration Note dated 8/17/20 at 12:37 PM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to the resident only has one on at this time, the resident's Physician aware and the resident had an appointment scheduled with the Physician. The Health Status Note dated 8/17/20 at 1:56 PM showed the resident continued to have right foot [MEDICAL CONDITION]. The resident had no complaints of pain or discomfort. OT was aware of the resident needing new compression stockings. The resident was enjoying being in their room and had no complaints of any kind. The Health Status Note dated 8/17/20 at 9:13 PM, the CNA reported the resident complained of left foot discomfort when they removed the stocking. The resident was in bed at the time with the lights out. The nurse asked the resident how their feet were feeling. The resident said the right foot still hurt but not as much, but it still hurt. The CMA reported the resident refused PRN Tylenol that evening. The Health Status Note dated 8/18/20 at 12:30 AM showed the resident with 2+ bilateral pedal [MEDICAL CONDITION]. The resident said the right foot was not as painful. The resident was using a wheelchair to transfer to and from the bathroom. The resident remained in isolation. The Occupational Plan of Care dated 8/18/20 showed the resident had a necessity for OT to address the underlying impairments. Without therapy, the resident was at risk for increased BOC and the adverse effects of progressive [MEDICAL CONDITION] untreated. The functional deficit section showed per the resident and the resident's family, the resident, did not wear the [MEDICAL CONDITION] compression garments for approximately one to two months as it was torn. The resident had an increase with lower extremity [MEDICAL CONDITION] and was sent to have tested with nursing reported no [MEDICAL CONDITION] or fracture. The resident was typically independent with functional mobility; however, due to increased [MEDICAL CONDITION] in the lower extremities, the resident now required the assistance of one staff per nursing judgment. The underlying impairments other sections showed that due to the resident's current [MEDICAL CONDITION], the patient's compression hose could not fit over the resident's lower extremities. The other compression garment was damaged and ineffective. The circumferential measurements showed the right extremity at 150.9 and the left at 148.1 centimeters (cm). The [MEDICAL CONDITION] grade dosume of bilateral feet is 4. The resident reported that bilateral lower extremities felt heavy and unable to currently utilize standard footwear for function mobility due to [MEDICAL CONDITION] of bilateral lower extremities. The Therapy Alert Note dated 8/18/20 at 4:04 PM indicated that per OT: [MEDICAL CONDITION] Management: 1. The resident's right leg was bandaged. Keep in place unless problems as listed below. * If signs of decreased circulation were noted, or if the resident complained of pain, numbness, or tingling, encourage the active movement of the bandaged leg(s). An assisted active range of motion (AAROM) or passive range of motion (PROM) may also be used. * If decrease circulation is still noted, or if the resident continued to have pain, numbness, or tingling after some form of exercise is tried, all bandages, foam, gauze, etc. should be removed, and OT should be notified. * Encourage leg elevation. * Wrap legs in plastic bags on bath days to prevent from getting wet. * Any other questions or instructions contact OT The Orders - Administration Note dated 8/18/20 at 5:18 PM showed the resident took two 325 milligrams (mg) [MEDICATION NAME] tablets due to complaining of right foot pain. The Health Status Note dated 8/18/20 at 7:32 PM indicated the resident had [MEDICAL CONDITION] wraps on the right leg. The resident tolerated the wraps well. The wraps were not to be taken off unless there were issues. The resident remained in isolation due to going to the emergency room (ER) to assess the right foot. The Health Status Note dated 8/19/20 at 2:14 AM said the resident was on day one with [MEDICAL CONDITION] wraps on the right foot. The resident reported no discomfort with foot or wraps on that shift. The resident was resting well on the shift. Staff entered the room to offer assistance with toileting, and the resident denied need at the time. The resident's right lower extremity was warm as usual, non-tender, and solid through the wraps. The resident's capillary refill was within normal limits. The resident's pedal pulses were unable to be heard or felt at the time. The Orders - Administration Note dated 8/19/20 at 1:35 PM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed to the right leg due to [MEDICAL CONDITION] wrap on the resident's legs. The Therapy Alert Note dated 8/20/20 at 10:11 AM indicated that Per OT: [MEDICAL CONDITION] Management: 1. The resident's left and right leg were bandaged. Keep in place unless problems as listed below. * If signs of decreased circulation are noted, or if the resident complains of pain, numbness, or tingling, encourage the active movement of the bandaged leg(s). An assisted active range of motion (AAROM) or passive range of motion (PROM) may also be used. * If decrease circulation is still noted, or if the resident continued to have pain, numbness, or tingling after some form of exercise is tried, all bandages, foam, gauze, etc. should be removed, and OT should be notified. * Encourage leg elevation. * Wrap legs in plastic bags on bath days to prevent from getting wet. * Any other questions or instructions contact OT The Orders - Administration Note dated 8/20/20 at 5:46 PM showed the resident took two 325 mg [MEDICATION NAME] Tablets due to the resident request for right foot pain. The Health Status Note dated 8/21/20 at 8:47 AM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to the resident continued with [MEDICAL CONDITION] wraps to bilateral lower extremities. The resident's active range of motion (AROM) was within normal limits. The resident denied difficulty with ambulation. The Orders - Administration Note dated 8/21/20 at 8:52 AM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to [MEDICAL CONDITION] wraps on. The Physician Visit note dated 8/21/20 at 9:30 AM, the resident had a physician visit with two Doctors for a follow-up to the [MEDICAL CONDITION] in the resident's legs. The Doctor's said to continue the higher dose of [MEDICATION NAME] until another follow-up in one week. The resident would continue having their legs wrapped as well. The resident did not have any other concerns at the time. The Health Status Note dated 8/21/20 at 7:38 PM showed the resident used a wheelchair due to being afraid their leg will swell up again or have pain. The resident was pleasant and cooperative. The resident denied pain and discomfort. The resident expressed only having a little pain when walking. The Orders - Administration Note dated 8/22/20 at 3:02 PM indicated the resident's order for Juzo socks on in the morning (AM) and off in the evening (PM) was not completed due to the resident having [MEDICAL CONDITION] wraps on both lower legs for [MEDICAL CONDITION]. The Orders - Administration Note dated 8/22/20 at 5:32 PM showed the resident took two 325 mg [MEDICATION NAME] tablets due to the resident complaining of right foot pain. The Orders - Administration Note dated 8/23/20 at 5:42 PM showed the resident took two 325 mg [MEDICATION NAME] tablets because the resident complained of right foot pain. The Care Plan problem dated 2/19/15, showed the resident had dementia and resided in the memory care area. The resident required some oversight and assistance with activities of daily living (ADL's). The intervention revised on 5/25/20 said the resident could complete dressing with cues & supervision for changing clothing items when soiled. The resident needed an assist of one staff with their compression stockings to put on in the morning and remove at bedtime. The Care Plan problem dated 5/25/20 showed the resident had [MEDICAL CONDITION], hypertension, heart valve disease, and [MEDICAL CONDITION]. The resident could get short of breath with exertion. The intervention dated 5/25/20 said the resident wore compression stockings to their resident's bilateral lower extremities. Staff was to encourage the resident to elevate their legs to help decrease [MEDICAL CONDITION]. The intervention dated 8/18/20 said per occupational therapy (OT), the resident required [MEDICAL CONDITION] management: 1. The resident's left and right leg were bandaged. Keep in place unless problems as listed below. * If signs of decreased circulation are noted, or if the resident complains of pain, numbness, or tingling, encourage the active movement of the bandaged leg(s). An assisted active range of motion (AAROM) or passive range of motion (PROM) may also be used. * If decrease circulation is still noted, or if the resident continued to have pain, numbness, or tingling after some form of exercise is tried, all bandages, foam, gauze, etc. should be removed, and OT should be notified. * Encourage leg elevation. * Wrap legs in plastic bags on bath days to prevent from getting wet. * Any other questions or instructions contact OT Follow-up interviews On 8/26/20 at 1:20 PM, the DON said the expectation if holes were seen in resident's compression stockings were to get screening and order as soon as screening was done. The DON said they did not know personally until about a month afterward until 8/11/20, when the [MEDICAL CONDITION] occurred. The DON said this should not have lasted a month that the nurses' responsibility as this was a medical necessity. 2. The MDS completed for Resident #3 with an ARD of 8/6/20 showed the resident had short-term and long-term memory problems, indicating severely cognitively impaired. The resident required extensive assistance of one staff with eating. The resident had no weight gain or weight loss. The resident ate a mechanically altered diet. The resident had [DIAGNOSES REDACTED]. Observations On 8/19/20 at 1:00 PM, observed the resident sleeping in bed. On 8/20/20 at 10:11 AM, observed staff providing pressure ulcer and perineal care to the resident. The resident was seen laying in bed. The resident's appearance was thin, with very little to no fat on the resident. Record review The Medication Administration Record [REDACTED]. The Med Pass was documented as refused eight out of 25 times offered. The MAR indicated [REDACTED]. The Med Pass was documented as given four times between 8/13/20 and 8/19/20, two times showed no documentation, and the resident showed refusal. The Weight Change Notification dated 7/16/20 showed the resident had a significant decrease in weight in one month of 5.6 percent (%). The resident's value at the time of notification was 101, with a prior weight of 107. The resident's usual weight was 113. The resident's body mass index (BMI)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	1037 19TH STREET SW MASON CITY, IA 50401

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) was 16.3. The Dietitian assessed and determined the possible reasons for the weight change was due to being recently hospitalized and now required staff assistance with eating. The resident was very sleepy and had dysphagia (difficulty swallowing). Trazadone was decreased, and the resident had Speech Therapy (ST) on 7/14/20. The Dietitian suggested increasing Med Pass to 3 oz three times a day. The Physician responded to see the fax log sheet on 7/23/20. The Weights & Vitals Note dated 7/17/20 at 9:03 AM showed the resident had a severe wt loss of 5.6% in one month from 107 pounds (#) to 101#. The resident was hospitalized from [DATE] to 7/12/20 with [MEDICAL CONDITION]. The resident now needed assistance with eating. The was very sleepy and now in a wheelchair. The resident's [MEDICATION NAME] dosage was reduced. On 7/13/20, the Doctor replied the basic metabolic panel (BMP) labs were good. The resident had ST. Between the Lewy Bodies and [MEDICAL CONDITION], the resident's ability to eat was difficult. An Iowa Physician order [REDACTED]. The resident had an appropriate plan from ST that for maximizing calorie intake. The resident was to be offered favorite foods first that took the most effort to chew, and later the foods that were naturally pureed. The resident won't eat pureed food, so the approach worked for increased calories and safety. The resident consumed approximately 900 kilocalories (Kcal) daily versus (vs) the needs of 1200-1400. The resident drank 100% of the Med Pass. The resident had inadequate oral food and beverage intake related to dysphagia, dementia, [MEDICAL CONDITION] as evidenced by severe wt loss, sleepy, low-calorie intake, texture preferences, and a BMI of 16.3. The plan was to increase the resident's Med Pass to 3oz three times a day. The Physician Notification fax sent on 7/23/20 showed the resident had a 5.6% weight loss in one month to 107#. The Physician returned the fax on 7/23/20, ordering a dietary consult for supplements. The Weights & Vitals Note dated 7/29/20 at 2:32 PM showed a nutrition consult per the Physician's request. The weight loss assessment sheet from 7/17/20 had not yet been sent to the Physician when assessing for supplements was written. An approval order for increasing Med Pass supplement to 3 oz three times a day was not yet signed. The resident ate all of two meals yesterday, and today he has slept too soundly to awaken for two meals. The resident ate cold cereal, so unable to do Super Cereal. The resident was given fork mashable foods to max intake of a safe texture that the resident would eat. The resident's current weight was 102# on 7/25/20, which was equal for three weeks. Staff requests a 206 Cookie for times the resident was awake - these were given. The Nutrition/Dietary Note dated 8/05/20 at 1:02 PM showed the resident was sleeping through lunch today. ST upgraded the resident's diet texture to mechanical soft with cut meat. The facility was still waiting on an order from the Doctor for Med Pass recommendation. The resident liked the 206 Cookies, which were given as needed (PRN). The resident weight of 104# remained stable for one month, continue with the same plan. The Nutrition/Dietary Note dated 8/13/20 at 9:45 AM showed a quarterly nutrition review: The resident's weight was 102# this week, showing stable for five weeks. The resident did wake for breakfast, and the resident ate 50% of the meal. The diet texture was upgraded on 8/4/20 to mechanical soft with cut meat, and the resident may have a burger whole. an order for [REDACTED]. Recommend adding a multivitamin with minerals and [MEDICATION NAME] Extra. Try the [MEDICATION NAME] Extra one at any time the resident was awake and ready to drink. If that goes well, increase to the recommended therapeutic amount twice daily-a continued goal for weight greater than 110# with a new goal for skin integrity. The Physician Notification fax sent on 8/13/20 indicated that per the Dietitian recommendation, the facility requests to increase the resident 2.0 Med Pass to 3 oz three times a day. The provider responded on 8/13/20 with a yes. The COMMUNICATION-with Physician note dated 8/13/20 at 12:07 PM indicated the facility received a fax back regarding the Med Pass recommendation to increase to 3oz three times a day. The Hospice Certification and Plan of Care dated 8/20/20 showed the resident had a sacral region stage III pressure ulcer. The nurse attempted to measure the wound at approximately 3.2 x 1.5 x 0.2 cm as the resident became uncooperative, and the resident had an old blister that healed. The Plan of Care had a goal to have an improved pressure ulcer, as evidenced by a decrease in size, drainage of the wound, absence of the infection, and decreased pain due to skilled intervention. The resident had a hospital bed with rails and a cushion for the wheelchair. The Physician certified the resident prognosis was six months of life or less if the disease ran its normal course. The Hospice Physician Narrative dated 8/20/20 indicated the resident had a failure to thrive with a current weight of 102# and a BMI of 16.9, which was a decline from weighing 116# from only a month ago which was a more than a 10% weight loss. The resident had a poor intake and appetite. The Hospice POC report dated 8/20/20 showed the problem of impaired skin integrity and the need for pressure ulcer care. The interventions dated 8/18/20 said to provide pressure ulcer care with a goal for the resident to verbalize tolerance to the pressure ulcer care. The Physician certified the resident prognosis was six months of life or less if the disease ran its normal course. Interview On 8/26/20 at 1:20 PM, the Director of Nursing said that a nurse should never wait longer than a shift to get an order for [REDACTED].
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 observation, clinical record review and interview, the facility failed to always complete accurate and timely assessments and communication to the physicians in a timely manner to ensure that all residents received treatment and care in accordance with professional standards for 2 of 6 residents reviewed (Resident #2 and #5). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) completed for Resident #2 with an Assessment Reference Date (ARD) of 6/25/20 showed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The resident was admitted to the facility on [DATE] from an acute hospital. The resident had a readmission date of [DATE] from an acute hospital. The resident was always incontinent of bowel and bladder during the seven day lookback period. The resident required extensive assistance of one staff with toileting and personal hygiene during the seven day lookback period. The resident had [DIAGNOSES REDACTED]. Observations On 8/19/20 at 2:38 PM, watched Staff G, CNA, and Staff H, CNA, assist the resident in the bathroom. Staff G and Staff F wash their hands. Staff G applied the gait belt around the resident's waist while Staff H applied gloves. The CNAs explained what they were going to do and then helped the resident sit on the toilet. Staff G removed their gloves and sanitized their hands. Staff H removed gloves and applied new gloves without completing hand hygiene. Staff H got the resident removed the resident's pants, held them while putting on the resident's fresh pullup, and then put pants back onto the resident. Staff H then removed old gloves and applied new gloves without hand hygiene. Staff G got out the wipes, then stood behind the resident and with wipe reached up to the vagina and wiped to the buttock. Then with a different hand, Staff G wiped the front of the resident and then removed gloves. The CNAs help the resident sit into the wheelchair. Record review The Health Status Note dated 6/10/20 at 1:32 AM showed the resident had extreme abdominal distention with complaints of pain when checking for bowel sounds. The bowel sounds showed active upper quadrants, with no audible sounds on the lower right quadrant and hypoactive (slow) sounds on the lower left side. The SpO2 was 94% on room air and temperature of 97.8. The resident's heart rate was 78. The resident was lying on the left side. The CNA's were concerned for several days of the resident's change in condition. The Health Status Note dated 6/10/20 at 2:37 AM explained that after evaluation by the east side, Registered Nurse (RN) confirmation received that bowel sounds were very hypoactive on the left lower quadrant with none on the right lower quadrant. Pain medication given at 6:00 PM kept her comfortable at the time. At 6:00 AM, planned to confirm with the DON and recommend the resident be sent to the emergency room (ER). The Health Status Note dated 6/10/20 at 7:46 AM documented the night shift nurse reported a change with the resident during the morning report. The night shift nurse said the resident with a distended abdomen, hypoactive bowel sounds, and the loose stools. The resident had loose stools over the last few days, in which an [MEDICATION NAME] order was received. The resident continued to have loose stools on and off. It was reported the resident with a decreased appetite. The nurse worked with the resident on and off. The resident was having all of the above on and off in the time the nurse worked with the resident. The resident now complained of pain with palpation of the abdomen. The resident left the facility with staff. A copy of the Medication Administration Record [REDACTED]. The COMMUNICATION - with Resident note dated 6/10/20 at 2:15 PM showed the facility received a report from the RN at the hospital. The resident was admitted for UTI and [MEDICAL CONDITION] with plans to get intervenous (IV) [MEDICATION NAME] for two days then the resident would return by the weekend. The History and Physical dated 6/10/20 showed the resident admitted due to abdominal pain and dysuria at the skilled nursing facility (SNF). The impression and plan showed [MEDICATION NAME] [DIAGNOSES REDACTED]. The resident had the additional [DIAGNOSES REDACTED]. The Hospital Progress Note dated 6/10/20 showed the resident's chief complaint was abdominal pain, [MEDICATION NAME], Diabetes Mellitus type 2, bacteremia, hypomag (low magnesium), and dementia. The resident appeared to be tired and weak. The Admission Summary dated 6/12/20 at 3:10 PM documented the resident arrived from the hospital via the facility van due to [MEDICATION NAME], diverticulitis, and UTI symptoms. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	**1037 19TH STREET SW MASON CITY, IA 50401**

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 0684

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 4)

Clinical Summary dated 6/12/20 showed the resident with [DIAGNOSES REDACTED]. The Hospital Discharge Notification signed by the Physician on 6/30/20 showed the resident's hospital [DIAGNOSES REDACTED]. The Care Plan problem dated 04/01/20 showed the resident at high risk for falls related to confusion, dementia, history of falls, incontinence, and psychoactive drug use. The intervention dated 4/1/20 said to offer routine toileting as the resident was incontinent of urine and has a history of UTI's. The resident did not always voice toileting needs. The resident was an assist of one with a gait belt for toileting. The Care Plan problem dated 3/31/20 said the resident had a UTI and was taking an antibiotic. The interventions dated 4/1/20 1. To encourage adequate fluid intake. 2. Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. 3. Monitor, document, and report to the Dr. PRN for signs and symptoms of a UTI such as frequency, urgency, malaise (weakness), foul-smelling urine, dysuria, fever, nausea, vomiting, flank pain, supra-pubic pain, hematuria (blood in urine), cloudy urine, altered mental status, loss of appetite, and behavioral changes. 4. Obtain and monitor lab or diagnostic work as ordered. Report results to the Dr. and follow up as indicated. The Care Plan problem dated 4/1/20 said the resident had [MEDICAL CONDITION] stage two. The resident had urinary incontinence with a history of UTI's. The interventions dated 4/1/20 1. Ensure thorough pericare and incontinence cares as the resident couldn't do themselves. 2. Monitor, document, and report for signs and symptoms of acute failure: Oliguria (urine output less than < 400 milliliters ml per 24 hours). Increased kidney labs (BUN and Creatinine). In the Diuretic phase (output >500 ml in 24 hours), the BUN and Creatinine level out. 3. Monitor, document, and report to the Dr. PRN for signs and symptoms of a UTI such as frequency, urgency, malaise, foul-smelling urine, dysuria, fever, nausea, vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, and behavioral changes. 4. Offer routine toileting as the resident does not always alert staff of the need to urinate. Follow-up interviews On 8/26/20 at 1:20 PM, the DON said that if a resident was having burning with urination, the expectation was to do an assessment and push fluids using nursing judgment. If this did not help the resident, the nurse could collect urine as a physician's orders [REDACTED]. If the interventions did not help, the nurse should notify the Physician either by calling or faxing them. If the resident had a history of [REDACTED]. The DON said the nurses did not have to wait to contact her before sending a resident to the Doctors. The DON also said the time of day never stopped a nurse from calling her before. 2. The MDS completed for Resident #5 with an ARD of 7/8/20 showed a BIMS score of 3, indicating severely cognitively impaired. The resident required extensive assistance of two staff with bed mobility, transfers, locomotion on the unit, dressing, toileting, and personal hygiene. The resident required limited assistance of two staff with locomotion off the unit. The resident required limited assistance of one staff with walking and eating. The resident was always incontinent with bowel and bladder. The resident had [DIAGNOSES REDACTED]. Interviews On 8/21/20 at 7:05 AM, Staff F, Certified Nurses' Aide (CNA), said the resident's bowel was coming out black or a darker color. Staff F reported telling the nurse, and the nurse didn't do anything. Staff F told another nurse that the stools were coming out darker, that nurse said that was a sign of internal bleeding. Staff F reported the resident wasn't feeling good and reported it to Staff O, Licensed Practical Nurse (LPN). Staff O said the resident told them they felt good. Staff F said they don't believe there were vital signs or anything else completed. On 8/24/20 at 1:07 PM, Staff E, CNA, said the resident had reddish, brown, watery, not formed, very watery stools. When Staff E reported it to the nurses, they said it was because they were giving him something to go. On 8/25/20 at 9:41 AM, Staff H, CNA, said the resident had troubles with their bowels. Every time the resident became constipated, they would keep screaming, then the staff gave the resident [MEDICATION NAME]. Currently, the resident was doing good with bowel movements. Record review The Orders - Administration Note dated 7/5/20 at 2:52 PM showed the [MEDICATION NAME] Powder held due to the resident having loose stools. The Orders - Administration Note dated 7/9/20 at 4:45 PM showed the [MEDICATION NAME] Powder held due to the resident having loose stools. The Documentation Survey Report for the month of 7/20 showed from 7/13/20 until 7/31/20; the resident had 12 days documented with at least once with a medium loose stool. The Physician Notification fax sent on 7/17/20 showed the Certified Nurses' Aides reported the resident had two loose stools on the 2:00 PM to 10:00 PM shift with no loose stools noted on the 10:00 PM until 6:00 AM shift. The resident was afebrile the time with a temperature of 98 degrees. The Physician responded on 7/20/20 with an order to collect the novel coronavirus 2019 (COVID-19) test. The Health Status Note dated 7/19/20 at 5:49 AM explained the CNA reported to the nurse that the resident had two loose stools on the 2:00 PM to 10:00 PM shift. No reported loose stools for the 10:00 PM to 6:00 AM shift. The resident was afebrile at this time with a temperature of 98.0 degrees. The nurse planned to continue to monitor the resident. The COMMUNICATION-with Physician note dated 7/19/20 at 6:52 AM showed the Doctor notified of the resident having loose stools via fax. The Health Status Note dated 7/19/20 at 5:45 PM showed the resident had one loose stool this shift at the time of charting. The resident denied pain or discomfort. The Health Status Note dated 7/20/20 at 12:12 PM explained the staff reported the resident had one loose stool up to the time of charting. The staff said the stool was all watery. The resident did not have any signs or symptoms of pain or discomfort. Effective Date: 07/21/2020 00:02 Type: COMMUNICATION-with Physician Note Text : Dr. Paltzer returned the fax regarding the resident having loose stools. PCP gave orders to obtain a COVID-19 test. The COVID-19 results dated 7/22/20 showed [MEDICAL CONDITION] not detected. The Health Status Note dated 7/23/20 at 9:49 AM showed the COVID-19 test results received and revealed to be negative. Fax sent to the Physician requesting to discontinue quarantine. The Health Status Note dated 7/30/20 at 1:28 PM indicated the staff reported the resident had one loose stool that shift. The loose stools were reported to the Physician previously. The resident was afebrile with bowel sounds active in all four quadrants. The abdomen was soft, non distended, and non-tender. The resident denied any pain or discomfort; this was added to the daily log. The Orders - Administration Note dated 8/3/20 at 1:04 PM showed Milk of Magnesia Suspension given due to the resident not having a bowel movement for two days. The Health Status Note dated 8/5/20 at 1:50 PM showed the resident did not have a bowel movement (BM) for five days. The resident's vital signs were a temperature of 97.7, a pulse of 98, respirations of 17, a blood pressure (BP) of 117/60, and an oxygen saturation (SpO20 of 97 percent (%) on room air (RA). The bowel sounds were active in all four quadrants. The resident's abdomen was noted to be soft, non-distended, slightly tender, and complained of a full feeling. The resident had as needed (PRN) Milk of Magnesia (MOM) on 8/3 and PRN Suppository today. The resident had issues with loose stools for the last month. The resident had ordered for [MEDICATION NAME] twice daily. Staff will encourage fluids. The resident's appetite varies, and the resident sleeps a lot. A fax was sent to the Physician. The Health Status Note dated 8/5/20 at 8:58 PM stated the resident did not have a BM for five days. The resident's bowel sounds were active in all four quadrants. The resident's abdomen was soft, non-distended, and non-tender. The resident had PRN MOM on 8/3/20 and PRN Supp today. The resident had an order for [REDACTED]. The Orders - Administration Note dated 8/5/20 at 1:38 PM showed a [MEDICATION NAME] suppository given. The Orders - Administration Note dated 8/5/20 at 10:57 PM indicated the [MEDICATION NAME] suppository PRN administration was ineffective. The Health Status Note dated 8/10/20 at 12:24 PM Staff reported the resident would not eat breakfast that morning but did drink two glasses of fluids. The staff just came from the resident's room for lunch. The resident took one bite and pocketed the food in their cheek. The staff was able to get the food out and left the resident with two more fluid glasses, which the resident was drinking when they left the room. The COMMUNICATION-with Physician note dated 8/10/20 at 3:38 PM showed the Physician paged at 3:00 PM and again at 3:30 PM to discuss symptoms of possible Ketoacidosis. The COMMUNICATION-with Physician note dated 8/10/20 at 3:55 PM indicated the Physician was paged again, and the Physician returned with a phone call. The nurse notified the Physician of signs and symptoms. The Physician gave an order to send to the emergency room (ER) to evaluate and treat for possible Ketoacidosis. The Physician requested the nurse ask the family if they would like the resident to go to the hospital or stay at the facility on comfort cares only. The Resident's Representative voiced understanding and requested the resident be sent to ER. The Resident's Representative did not want extensive treatment. The resident's Medication Administration Record [REDACTED]. The COMMUNICATION-with Physician dated 8/10/20 at 9:32 PM explained the hospital called and informed the nurse that the resident was admitted for possible pneumonia and gastrointestinal (GI) bleed, as blood was found in the resident's stool. The review of the MAR for the month of 8/20 showed [MEDICATION NAME] documentation every day until 8/10/20. The MAR for the month of 8/20 showed milk of magnesia (MOM) 30 milliliters (ml) given on 8/3/20 and charted as ineffective. The MAR for the month of 8/20 showed a [MEDICATION NAME] 10 milligrams (mg) suppository given on 8/5/20 and charted as ineffective. The Admission Summary dated 8/17/20 at 1:25 PM indicated the resident readmitted back to the facility from the hospital due to [MEDICAL CONDITION], weakness, and [MEDICATION NAME]. The Documentation Survey Report for the month of 8/20 showed from 8/1/20 until 8/10/20; the resident had seven days documented with at least once with a medium loose stool. The resident had a bowel movement on the following dates from 8/1/20 through 8/10/20. 8/1/20 - Incontinent Loose Medium 8/3/20 - Incontinent putty small 8/4/20 - Incontinent Loose Medium 8/6/20 - Incontinent Loose Medium BM and Incontinent Loose Medium 8/7/20 - Incontinent Loose Large 8/8/20 - Incontinent Loose Large two shifts 8/9/20 - Incontinent Loose Medium 8/10/20 - Incontinent Loose Medium The resident's record lacked further interventions or notification to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	**1037 19TH STREET SW MASON CITY, IA 50401**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) Physician after 7/20/20 regarding the resident's loose stools. Follow-up interview On 8/26/20 at 1:20 PM, the Director of Nursing said that if an intervention did not improve the problem, then the Physician needed to be notified either by a call or a fax.
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 interviews and record review, the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcers, failed to provide the necessary treatment and services to promote the healing of pressure ulcers and to avoid infection for three of four residents reviewed (Resident #2, #3, and #5). The facility reported a census of 74. Findings include: 1. The Minimum Data Set (MDS) completed for Resident #3 with an Assessment Reference Date (ARD) of 8/6/20 showed the resident had short-term and long-term memory problems, indicating severely cognitively impaired. The resident required extensive assistance of one staff with eating. The resident had no weight gain or weight loss. The resident ate a mechanically altered diet. The resident had [DIAGNOSES REDACTED]. Observation On 8/20/20 at 10:11 AM, observed Staff D, Licensed Practical Nurse (LPN), walk to the resident, and explain what they were doing. Staff D removed the resident's dressing labeled 8/19/20 as the resident laid calmly on the bed. Staff D took the wound cleaner and gauze then sprayed the resident's wound to wash the wound. The wound was seen to be superficial in-depth on the coccyx. Staff D placed a white dressing to the wound then covered with a transparent dressing. Staff D then removed the gloves and labeled the dressing on the resident with a sharpie. Also noted a large dark pink area with peeling dry skin to the left heel. Interviews On 8/20/20 at 9:03 AM, Staff D said one nurse thought the area was a blister while another thought it was a Kennedy Terminal Ulcer (KTU). If the nurse was unsure, they should get the doctor involved in Staff D's opinion, mostly if there was a Kennedy ulcer's concern. If there was a concern with skin issues, the wound nurse could consult with the opinion difference. On 8/20/20 at 11:05 AM, Staff B, Certified Nurses' Aide (CNA), said they reported the area to the nurse approximately two weeks before. Staff B said they noticed blisters that looked pretty bad. Staff B said the area was reported to another nurse by someone else before they reported it sometime before 8/13/20. Staff B said they believed nurses were putting some iodine on the blister. Staff B said the blister was intact when they first saw it. One of the blisters was full, and one on the bottom of the foot had popped. The area looked like there was a blister there before. Staff B said they noticed the wound to the resident's buttocks and reported it to the nurse, who said it was already reported. On 8/20/20 at 11:27 AM, Staff A, LPN, explained they didn't usually work in that area but said they knew the resident had a stage III (3) pressure ulcer on their backside. Staff A said that things might have already been addressed, but if it were reported to them, they would report it because they felt it was important to notify the doctor. On 8/20/20 at 12:24 PM, Staff N, CNA, said the area to the resident's heel was there maybe a week to two weeks. Staff N said they found the area to the resident's coccyx when they showered the resident. The resident was mainly in the recliner because of their anxiety, but now the resident didn't move much. Staff N said the resident would sometimes allow a cushion in the recliner but would sometimes push the cushion out. The resident could be sleeping then could wake up and be on the floor. Due to the resident's decline and decreased anxiety, the staff put the resident in the bed. On 8/24/20 at 1:07 PM, Staff E, CNA, said they saw the resident's pressure area. Staff E reported telling the nurse around a month ago. Staff E said they reported the wound to Staff C, LPN. Staff E reported being in the bathroom with the resident when it was found. Staff E said they had the resident stand up to show Staff C the area to the coccyx. Staff E said Staff C said okay and did not tell them what to do, so they put a cream on the wound. Staff E said that the nurses usually chart on the wounds, and CNAs don't have anywhere to chart on it. Staff E said they could only tell the nurse. On 8/24/20 at 3:15 PM, Staff C said the wound started about three to four weeks ago. Staff C said the doctor was faxed to get the wound dressed using a barrier cream. Staff C said they didn't know who it was reported to and couldn't remember if it was reported to them. Staff C said they get things reported to them all of the time. On 8/25/20 at 8:48 PM, Staff K, CNA, reported finding out about the wounds when everyone else knew about it. Staff K said they did not find it. Staff K stated the wound wasn't there very long, maybe a couple of weeks. Staff K reported not being good at knowing the time but said the heel was there longer than the buttock. The area to the heel came and went. The resident was to wear pressure boots while keeping their heels up but said the resident wouldn't always keep the pillow under their legs. Somedays, the resident would be up all day, all night, or both. The resident usually told them when they needed to go to the bathroom. The resident would sleep in the recliner. Most of the time, the resident had a cushion, but the resident would take it out so they didn't have a cushion in the recliner because they didn't like it. The pressure sore on the resident's buttock was recent and not very long. On 8/25/20 at 9:41 AM, Staff H, CNA, stated that they saw the resident's area to the buttocks around 8/4/20 or 8/5/20. Staff H reported telling Staff C to look at the resident's buttocks as it was just starting to have a sore. Staff C looked at the area but did not say anything. Staff H said they did not see the resident's blister on the heel. Staff H said they came back to work around 8/7/20 or 8/8/20, and the nurse said they just found it as it was only reported that day. Staff H said they did not chart on the area on 8/4/20 as they told the nurse that the area was just starting to open, and it was very red. On 8/25/20 at 2:36 PM, Staff V, LPN, said if they get a complaint, they document it and then report it to the next shift coming on. Staff V said that sometimes things change from one shift to another. Staff V reported the nurses were dressing the resident's wound to the buttock and were overseeing things. Staff V said the resident had two different orders for dressings, and the current dressing was working. On 8/26/20 at 1:50 PM, Staff N said the resident slept in the recliner because the family requested him to sleep there. The resident slept in the recliner because the resident kept trying to get up, and they were afraid the resident would fall. The resident had a cushion, but they kept pushing it out. Staff N did not remember anything else tried. Staff N said the staff would walk the resident as they were able. Record review The Fax Transmittal Log Sheet dated 8/7/20 documented the staff reported the resident had a heel blister measuring 5.4 by (x) 5.5 centimeters (cm). The area was clean, dry, and intact. The left foot was elevated, and [MEDICATION NAME] was applied. They requested an order for [REDACTED]. The blister was intact with no redness, warmth, or drainage. No apparent rubbing was seen where this could develop-the resident wearing socks and slippers at times. The resident sat in the wheelchair at supper, and the majority of the day up in the recliner. The resident's heels float up on a pillow, the resident was up in the recliner with their legs up, and iodine applied. The nurse faxed the doctor and called the wife. The resident showed no signs of pain or discomfort. The Health Status Note dated 8/8/20 at 2:39 AM indicated the resident's fluid-filled blister was flat. The resident had no drainage or redness noted. The resident's heel was offloaded on the pillow. A skin sheet was initiated, and the nurses would continue to monitor. The Skin/Wound Note dated 8/8/20 at 9:45 AM indicated no blister noted to the left heel. The left heel had a small dark, a discolored area measuring approximately 0.4 x 0.4 cm with no open area. There did not appear to be raised. The resident had no signs or symptoms of pain or discomfort. The staff attempted to float the resident's heel, with no avail. The resident would move the foot back on top of the footrest. The staff would try boots. The Skin/Wound Note dated 8/8/20 at 6:55 PM stated the resident did not have a fluid-filled blister to left heel. The left heel had a small dark, a discolored area with no open area noted. The resident showed no signs or symptoms of pain or discomfort. The 24 Hour Follow-up Incident note dated 8/9/20 at 2:56 AM documented a follow-up on the left heel's burst blister. Upon assessment, the staff noted the fluid-filled blister to the same area on the left heel. The heel showed no redness, signs, or symptoms of infection. The heels were offloaded as much as the resident would tolerate. The nurses would continue to monitor. The Skin/Wound Note dated 8/9/20 at 7:41 AM indicated that after the resident's whirlpool, the staff observed an area to the coccyx. The area measured 1.9 x 1.0 x 0.15 cm. The wound bed was pink with frayed skin to the left side. The resident complained of pain during the examination. The wound had no drainage noted at the time of the examination. The area had no increased redness noted to the peri-wound. The wound appeared to be a stage 3 pressure injury. A fax was sent to the doctor, and a skin sheet was initiated. The Skin/Wound Note 8/9/20 at 11:06 AM stated the nurse could visualize and observe a deflated blister. The resident flinched when examined. The area covered a large part of the left heel with no increased redness or warmth noted. The resident was up per usual with some agitation noted with care and repositioning. The Fax Transmittal Log Sheet faxed on 8/9/20 explained the staff observed an area to the coccyx after the resident's whirlpool. The area measure 1.9 x 1.0 x 0.15 cm. The wound bed was pink with frayed skin to the left side. The resident complained of pain with the examination. No drainage was noted at the time. No increased redness was noted to the peri-wound. They requested to use a pressure skin sheet and mark the wound as a stage III. The staff asked if the wound was a KTU with the recent decline. The staff asked if the resident could have an order for [REDACTED]. The Health Status Note dated 8/9/20 at 5:26 PM showed a fluid-filled area remained to the left heel. Prevalon Boots were intact to both of the resident's feet. The blistered area remained closed. The coccyx pressure area was noted to be red and open with a scant amount of blood at the site. The wound/skin nurse to evaluate tomorrow per the nurse report. The Skin/Wound Note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	**1037 19TH STREET SW MASON CITY, IA 50401**

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 - Actual harm

Residents Affected - Few

(continued... from page 6)

8/10/20 at 2:39 AM indicated a fluid-filled area remained to the left heel. Prevalon Boots were intact to both of the resident's feet. The blistered area remains closed at this time. An open area to the resident's coccyx reddened with a scant amount of bloody drainage. The area was cleansed, and a protective dressing was applied. The wound nurse was notified and was aware. The resident was up two times for toileting and repositioning into the wheelchair with scheduled Tylenol given. The Skin/Wound Note dated 8/10/20 at 7:51 AM stated there was no order for the wound nurse. Fax out to the doctor with the request. The COMMUNICATION-with Physician note dated 8/10/20 at 1:31 PM documented the facility received a fax back about the resident's blister and area to the coccyx. The fax showed an order of [MEDICATION NAME] twice daily to the left heel. The facility received a new order for a wound consult and okay to mark the area as a pressure ulcer stage 3 to the coccyx. The Infection Preventionist informed the new order as they completed a zoom visit with a wound consultant. The facility also asked to stage it as a KTU due to the resident's recent decline. The Wound Care Skin Integrity Evaluation dated 8/10/20 showed the resident had a wound on the coccyx that started on 8/9/20. The assessment was completed on 8/10/20 with variable minimum to moderate exudate with a full-thickness stage three pressure ulcer. The wound measured 1.90 x 1.00 cm with a depth of less than (<) 0.2 with a Pressure Ulcer Scale for Healing (PUSH) score of 7.00 with no tunneling or undermining. The wound had serosanguineous drainage. The wound was facility acquired. The wound bed was 100 percent (%) red, friable (fragile/bleeds), and or dusky. The periwound / wound edges showed the periwound tissues were intact and uninvolved tissues flush with the wound base. The wound edges / Margins were irregular wound edges. The additional periwound / wound edge showed a mild [DIAGNOSES REDACTED]/purple hue. The wound showed no pain. The clinical ration/wound comments stated that Collage AG stimulates the growth of granulation and provides sustained antimicrobial action to the wound. A bordered hydrogel dressing was to be used to sustain a moist wound environment that promotes autolysis (the breakdown of all or part of a cell or tissue by self-produced enzymes) and moist wound healing. Daily dressing changes were needed because the dressing became dislodged within 24 hours due to moisture or incontinence. The treatment intervention said to clean the coccyx wound per the facility protocol. Apply Collagen AG, cover with hydrogel bordered dressing, then change dressing daily and as needed (PRN). The Skin/Wound Note dated 8/10/20 at 1:18 PM explained the resident had a Zoom meeting with the wound consultant. Examined and assessed the area to the coccyx, discussed the right heel and overall decline. The wound note stated it might be KTU but would wait to see if the treatment would respond. The recommendation was received and forwarded to the doctor for review. The Fax Transmittal Log Sheet dated 8/10/20 indicated the facility could initiate the treatment to cleanse the coccyx wound per the facility protocol. Then apply Collagen AG and cover with hydrogel bordered dressing. Then change the dressing every day and PRN. The doctor responded yes on 8/13/20. The Skin/Wound Note dated 8/11/20 at 10:52 AM showed the resident had a fluid-filled area to the left heel. Bilateral Prevalon boots were intact to the resident's feet. The blistered area remained closed at the time to the heel, and an open area to the coccyx remained reddened with no drainage. The area was cleansed, and a dressing was applied. The Skin/Wound Note dated 8/11/20 at 6:50 PM explained the resident had a fluid-filled area to the left heel. Bilateral Prevalon boots were intact to the resident's feet. The blistered area remained closed to the heel, and an open area to the coccyx remained reddened with no drainage. The area was cleansed, and a dressing was applied. The Braden Scale for Predicting Pressure Sore Risk dated 8/11/20 showed a score of 18, indicating a mild risk for developing a pressure ulcer. The Skin/Wound Note dated 8/12/20 at 12:10 AM showed the resident had a fluid-filled area to the left heel. Bilateral Prevalon boots were intact to the resident's feet. The resident was sleeping in the recliner in the lounge. The Skin/Wound Note dated 8/12/20 at 3:01 PM indicated the resident continued to have an area to the back of the left heel and the coccyx. The dressing to coccyx remained intact and unsoiled. [MEDICATION NAME] applied to the left heel. The blister remained intact and fluid-filled. The resident showed no signs or symptoms of pain or discomfort with the treatment. The resident was resting in the recliner with boots on. The Fax Transmittal Log Sheet faxed on 8/12/20 showed the resident's blister on the left heel kept draining and filling back up with fluid. They asked if an antibiotic was necessary. The doctor responded on 8/13/20 said not if the liquid was not puss. The patient would be seen in their room on Zoom. The Nutrition/Dietary Note dated 8/13/20 at 9:45 AM showed a quarterly nutrition review. The resident had two new pressure injuries to the heel and coccyx. The Dietitian recommended adding a multivitamin with minerals and [MEDICATION NAME] Extra. Try the [MEDICATION NAME] Extra one at any time the resident was awake and ready to drink. If that goes well, increase to the recommended therapeutic amount twice daily: a continued goal for weight greater than 110 pounds (#) with a new goal for skin integrity. The COMMUNICATION-with Physician note dated 8/13/20 at 12:12 PM stated the facility received a fax back about the blister on the heel with no new orders - also received a fax about a multivitamin and supplement. The fax showed a new order for a multivitamin with minerals daily and [MEDICATION NAME] Extra one carton by mouth daily. The Physician Visit note dated 8/13/20 at 12:37 PM showed an acute telehealth visit with the doctor per their request. The left heel and the left lateral ankle were examined and assessed. A new order was received to increase [MEDICATION NAME] treatment three times a day to the left heel and ankle. The doctor requested extra cushioning in the boot. The floor nurse notified, and the electronic Medication Administration Record [REDACTED]. The Resident's Representative voiced understanding about the extra padding to the boots and the resident's decline. The Nutritional assessment dated [DATE] showed the resident had a skin condition of a blister to the heel as of 8/10/20 and a stage III to the coccyx as of 8/9/20. The resident had a loss of 3.7 % in one month and 6.3% in six months. The resident was seen by speech therapy (ST) between 7/20 and 8/20. The resident's mobility level indicated was the recliner. The resident slept a lot and was alert to only one sphere. The New Order Follow-up Note dated 8/13/20 at 1:03 PM indicated the resident continued to have an area to the heel, ankle, and the buttock. The night shift nurse stated before starting the shift, they assessed the area to buttock with clean, intact dressing. Per the doctor's orders, they did not apply [MEDICATION NAME] as the doctor wanted to look at the resident's heel at the visit at noon that day. The doctor did observe the area to the heel with another nurse. The area to the heel continued with a large intact fluid-filled blister. The resident did not appear to have any pain or discomfort. The Orders - Administration Note dated 8/13/20 at 3:57 PM indicated increased cushioning in the Prevalon boots with a thick foam or sheepskin to prevent further skin issues was not done due to the facility not having it yet as they were waiting on the foam. The COMMUNICATION-with Physician dated 8/13/20 at 5:05 PM documented the facility received signed fax regarding the treatment and the wound nurse's suggestion. The doctor responded Okay. The treatment administration record (TAR) was updated. An order was received to clean the coccyx wound per the facility protocol. Then apply collagen AG and cover with a hydrogel border dressing. Change the dressing daily and PRN. The Physician's Telephone Orders Audit, dated 8/13/20, showed a change in the [MEDICATION NAME] treatment three times a day to the left heel and left lateral ankle blister. With an order to increase the cushioning in the boots with thick foam or sheepskin. The Fax Transmittal Log Sheet dated 8/13/20 said the resident had new pressure injuries to their heel and coccyx. They requested to have an order for [REDACTED]. The Skin/Wound Note dated 8/13/20 at 9:27 PM explained the resident coccyx was intact with no change, no drainage, or warmth. The resident was assisted with pericares and up to the bathroom every two to three hours. The resident left heel intact, noted raised, mushy, and soft to touch. The fluid inside the blister was red with a spot of green. The blister had a foul odor, but the resident showed no facial grimacing or signs of pain. The Orders - Administration Note dated 8/13/20 11:31 PM indicated increased cushioning in the Prevalon boots with a thick foam or sheepskin to prevent further skin issues was not done due to it not being available. The Health Status Note dated 8/14/20 at 1:00 AM explained [MEDICATION NAME] was applied to the left heel blister. No changes were noted from using the [MEDICATION NAME] treatment. The blistered area was soft and filled with bloody greenish fluid. The resident showed no signs or symptoms of pain. The resident was wearing Prevalon boots. The Weekly Skin Sheet dated 8/14/20 showed the resident had a blister to the left heel that measured 5.5 x 5.4 cm. The fluid-filled blister had no redness that popped with scant drainage. The Skin/Wound Note dated 8/14/20 at 1:19 PM documented the initial treatment to the coccyx applied without difficulty. The resident tolerated the treatment well. The New Order Follow-up Note dated 8/14/20 at 1:36 PM showed no initial dose of the multivitamin or [MEDICATION NAME] was given as the resident slept. The [MEDICATION NAME] applied to the heel and ankle per order without difficulty. The blister to the ankle was still inflated and intact. The Health Status Note dated 8/14/20 at 7:31 PM indicated [MEDICATION NAME] was applied to the left heel blister. No changes were noted from using the [MEDICATION NAME] treatment. The resident showed no signs or symptoms of pain-the resident wearing Prevalon boots. The Health Status Note dated 8/15/20 at 12:11 PM showed the resident remained in bed for the shift. The staff repositioned the resident every two hours. The dressing was changed to the coccyx area as ordered. Dark brownish-yellow drainage was noted with odor to the old dressing. The [MEDICATION NAME] treatment was applied to the left heel areas. The skin remained intact with Prevalon boots in place with sheepskin to the left lower extremity. The Health Status Note dated 8/16/20 at 5:15 AM explained that as [MEDICATION NAME] was applied to the left heel, a slight amount of fluid drained from the blister. The Health Status Note dated 8/17/20 at 4:33 AM indicated the resident's blister to the left heel drained. The heel had a skin flap. The resident was to have a hospice consult today, and Hospice would be made aware of skin issues. A report was given to the 6:00 AM to 2:00 PM nurse to follow-up on mottling noted to the resident's right leg. The resident was resting in bed. The Health Status Note dated 8/17/20 at 9:00 PM explained the resident was observed in bed for the 7:00 PM to 10:00 PM shift. The resident was moving arms and laying with eyes open. The nurse assisted the CNA with repositioning. The nurse observed the blister to the left heel to be open with a skin flap rolled up and hard, pressing against the heel. A [MEDICATION NAME] pad was placed under the heel for protection. A partial skin flap remained snug against the heel. A note was left for the doctor and day nurse to look at the area. The Health Status Note dated 8/17/20 at 11:41 PM documented the resident rested quietly in bed. The scheduled Tylenol was given and tolerated well. No drainage was noted from the blister to the left heel, and a [MEDICATION NAME] dressing was placed under the heel. Prevalan boots were on bilateral feet as the resident was repositioned. The Staff was to continue to monitor the resident. The Orders - Administration Note dated 8/18/20 at 1:07 AM explained that [MEDICATION NAME] to the blister on the left heel and the left lateral ankle was not done as the blister was open and draining. The Health Status Note dated 8/18/20 at 4:47 AM stated the nurse called and spoke with the hospice nurse. Discussed the need for them to come today and admit the resident to hospice services and the need for pain medication. The hospice nurse stated they would look into the resident's orders for hospice services and call back later in the morning with an update. The Orders - Administration Note dated 8/18/20 at 7:35 AM explained [MEDICATION NAME] to the blister on the left heel and the left lateral ankle was not done as the blister was open. The Orders - Administration Note dated 8/18/20 at 5:14 PM explained that [MEDICATION NAME] to the blister on the left heel and the left lateral ankle was not done as the blister was open. The Orders - Administration Note dated 8/19/20 at 4:13 AM, explained that [MEDICATION NAME] to the blister on the left heel and the left lateral ankle was not applied per nursing judgment. The Health Status Note dated 8/19/20 at 4:52 AM documented the resident kept the boots on for about three hours, and no [MEDICATION NAME] was applied to the wound per nursing judgment. The COMMUNICATION-with Physician note dated 8/19/20 at 7:20 AM showed fax was sent to the doctor regarding the resident's [MEDICATION NAME] treatment. The Orders - Administration Note dated 8/19/20 at 7:21 AM explained [MEDICATION NAME] to the blister on the left heel and the left lateral ankle was not done as fax was sent to the doctor to clarify the treatment. The Hospice Note dated 8/19/20 at 1:43 PM documented the resident's skin was warm and dry with normal tones. No mottling was noted so far this shift. The treatment of [REDACTED]. The area was noted with some improvement. No signs or symptoms of pain were noted with the dressing change. The resident remained in bed and appeared comfortable. The resident was repositioned every two hours with oral care performed at that time. The Health Status Note dated 8/19/20 at 1:50 PM indicated the left heel continued to be open with no drainage-fax sent to the doctor regarding the treatment. The Physician's Fax form dated 8/19/20 showed the resident had an order for [REDACTED]. The facility requested to change the order to apply [MEDICATION NAME] to intact skin or blister. The Physician responded yes on 8/19/20. The Weekly Skin Sheet dated 8/19/20 showed the resident had a blister to the left heel's backside measuring 5.6 x 6.4 cm with a date of onset of 8/7/20. The comments indicated the blister was flat with drainage apparent. The resident also had a stage III pressure ulcer to the coccyx that started on 8/9/20. The skin was frayed on the left

side. The Skin/Wound Note dated 8/20/20 at 8:09 AM, the wound consultant, was notified of the resident's admission to Hospice Services. The Hospice Certification and Plan of Care dated 8/20/20 showed the resident had a sacral region stage III pressure ulcer. The nurse attempted to measure the wound at approximately 3.2 x 1.5 x 0.2 cm as the resident became uncooperative, and the resident had an old blister that healed. The Plan of Care had a goal to have an improved pressure ulcer, as evidenced by a decrease in size, drainage of the wound, absence of the infection, and decreased pain due to skilled intervention. The resident had a hospital bed with rails and a cushion for the wheelchair. The Physician certified the resident prognosis was six months of life or less if it ran its normal course. The Hospice Plan of Care (POC) report dated 8/20/20 showed the problem of impaired skin integrity and the need for pressure ulcer care. The interventions dated 8/18/20 said to provide pressure ulcer care with a goal for the resident to verbalize tolerance to the pressure ulcer care. The Physician certified the resident prognosis was six months of life or less if it ran its normal course. The New Order Follow-up Note dated 8/20/20 at 6:39 PM, showed the resident rested comfortably in bed. The resident was repositioned throughout the shift by the CNA's. The resident rested on the right side with pillows supporting their back. Bilateral Prevalon boots remain on while in bed with sheepskin protector in place. The dressing was intact on the resident's buttock, and the left heel appeared to be healing with no drainage. Follow-up interviews On 8/26/20 at 2:15 PM, the Infection Preventionist said the area was reported to them after the resident's shower, said it was a few days after it opened. The Infection Preventionist told if it wasn't documented, it wasn't addressed. On 8/26/20 at 1:20 PM, the Director of Nursing (DON) said the expectation was always to look and document. If something was not documented, it wasn't done. Even if it was just a scratch, it was best to document it. The DON said they couldn't back the staff if it wasn't documented or done. 2. The MDS completed for Resident #2 with an ARD of 8/13/20 showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was admitted on [DATE] with a stage IV pressure ulcer. The resident required pressure ulcer care. The resident had a pressure-relieving device in the bed and chair. The resident required extensive assistance of one staff with bed mobility, dressing, transfers, and toileting during the seven day lookback period. The resident exhibited no instances of rejection of care during the seven day lookback period. The resident showed verbal and other behaviors for one to three days in the last seven days in the lookback period. The resident used opioids for seven of seven days of the lookback period. The resident was always incontinent of bowel and bladder in the seven day lookback period. The resident had [DIAGNOSES REDACTED]. Resident interview On 8/19/20 at 1:03 PM, the resident said they didn't like it at the facility and planned to go home on 9/1/20. The staff did treatments to their bottom without issues. The resident said they never tell the staff that they didn't want it done. The resident said that they took that back; the resident said that two times they would wait until after they smoked. The resident reported the staff knew they didn't like to get dressed and get into the chair. Then the resident would have to get back into the bed. Then the staff would have to remove their clothes. The resident said that was not right. The staff would come in to do the resident's treatment around 8:00 AM. The resident reported the staff were friendly to them and took good care of their pain. Observation On 8/24/20 at 4:41 PM, Staff A prepared the resident to transfer with a mechanical lift. Staff E wore a face mask with a face shield while Staff A only wore a face mask. Staff A and Staff E transferred the resident with the mechanical lift to the bed. Staff A removed their name badge and placed it on the empty bed in the resident's room. The resident was incontinent with urine. Staff A removed wipes from the package, and Staff A wiped the resident's front. With used gloves, Staff A removed more wipes from the package leaving leftover wipes on top of the package. Staff E rolled the resident, and Staff A removed the resident's brief, then removed gloves and applied new gloves without hand hygiene. Staff A touched the resident's backside and then opened the new bulk gauze package without hand hygiene. No dressing to the wound. Staff A reported not knowing how to complete the new dressing change. Staff E rolled the resident and Staff A sprayed wound cleaner into the wound, then wiped the area with gauze. Staff sprayed the wound again and wiped with more gauze. The resident began to urinate; Staff A held the resident in place as they finish urinating. Staff A then used wipes off the top of the package to wipe the resident, then removed gloves. Observed a superficial pink dime-sized area with a red center to under the gluteal fold on the left leg and the pressure ulcer on the resident's coccyx. Staff A inserted a dressing into the wound while saying this piece is supposed to go first. Then bunches up sheets of collagen; Staff A said I hope this was right, I don't know how to do this. Then pushed the bunched sheet of collagen into the wound. Staff A then said this is supposed to go outside the wound while holding another dressing. The dressing showed a number one on the outside. Staff A removed the paper on the dressing on the other side of the number one. Attempted to place onto the resident, then removed the paper on the side with the number one. As Staff A continued to try to place over the wound, the dressing began to roll. Staff A removed gloves while stating no one knew how to

F 0690

Level of harm - 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 observations, interviews, and record reviews, the facility failed to address symptoms of a urinary tract infection [MEDICAL CONDITION] for one resident reviewed (Resident #1). The facility reported a census of 74 residents. Findings include: The Minimum Data Set (MDS) completed with an Assessment Reference Date of 6/25/20 showed a Brief Interview for Mental Status score of 5, indicating severe cognitive impairment. The resident was admitted to the facility on [DATE] from an acute hospital. The resident had a readmission date of [DATE] from an acute hospital. The resident was always incontinent of bowel and bladder during the seven day lookback period. The resident required extensive assistance of one staff with toileting and personal hygiene during the seven day lookback period. The resident had [DIAGNOSES REDACTED].

Observations On 8/19/20 at 2:38 PM, watched Staff G, CNA, and Staff H, CNA, assist the resident in the bathroom. Staff G and Staff F wash their hands. Staff G applied the gait belt around the resident's waist while Staff H applied gloves. The CNAs explained what they were going to do and then helped the resident sit on the toilet. Staff G removed their gloves and sanitized their hands. Staff H removed gloves and applied new gloves without completing hand hygiene. Staff H got the resident removed the resident's pants, held them while putting on the resident's fresh pullup, and then put pants back onto the resident. Staff H then removed old gloves and applied new gloves without hand hygiene. Staff G got out the wipes, then stood behind the resident and with wipe reached up to the vagina and wiped to the buttock. Then with a different hand, Staff G wiped the front of the resident and then removed gloves. The CNAs helped the resident sit into the wheelchair.

Record review The Urine Culture dated 3/31/20 showed the resident was treated with [MEDICATION NAME] VK 500 milligrams (mg) orally three times a day for five days due to catheterized urine showing greater than (>) 100,000 colony-forming streptococci, beta-[DIAGNOSES REDACTED] group B (Urinary Tract Infection UTI) and dysuria (pain with urination). The Dietitian Assessment for 4/13/20 showed the resident had a UTI on 3/31/20. The Clinical Nursing Home Note dated 6/2/20 showed the resident visited with the Physician via telemedicine. The resident denied pain at the time of the visit, but the staff said the resident seemed bloated with a decreased appetite. Due to the assessment, the Physician ordered [MEDICATION NAME]. The Physician noted the resident was not real distended at that time. The Physician Visit note dated 6/2/20 at 12:19 PM showed the resident had a 60-day recertification visit with the Doctor (Dr.) via telehealth. The nurse, per Dr.'s request, performed the physical assessment. The resident's vital signs (VS), medications, and blood sugars were reviewed. New order received for [MEDICATION NAME] 80 mg chew to give after each meal and at bedtime, [MEDICATION NAME] PM one hour before bedtime, and talk to the resident's family regarding the donepezil to determine if it was ok to discontinue? The New Order Follow Up Note dated 6/2/20 at 7:31 PM showed the resident had an initial dose of [MEDICATION NAME] and [MEDICATION NAME] with no adverse effects noted. The New Order Follow Up Note dated 6/3/20 at 1:47 PM showed the resident was up as usual. No signs or symptoms of adverse reactions were noted related to the start of [MEDICATION NAME]. Bowel sounds active in all four quadrants. The abdomen was noted to be soft, round, and slightly tender with palpation. The resident denied any abdominal discomfort. The resident slept through breakfast but ate 100 percent (%) of lunch without difficulty-no complaints of gas. The Health Status Note dated 6/7/20 at 12:38 PM showed the resident with VS of temperature of 97.7, a pulse of 75, respirations 18, blood pressure (BP) of 163/72, and oxygen saturation (SpO2) 98% on room air. The resident had three loose stools since the previous shift. Bowel sounds active in all four quadrants. The abdomen was noted to be soft, non-distended, slightly tender with palpation. The resident was up per usual. The resident's appetite was per usual, but the resident had an occasional loose stool. The Health Status Note dated 6/7/20 at 8:51 PM documented the staff reported the resident had two loose stools that shift. The resident was in good spirits, up to supper, and consumed the meal without difficulty. The resident showed no facial grimacing, complaints of pain or discomfort, the resident's abdomen non-tender, and non-distended with bowel sounds active in all four quadrants. The resident noted to be afebrile (no fever) and passing gas with a noted foul odor from the resident throughout the shift. The Physician Communication dated 6/7/20 showed a request for Immodium due to the resident having loose stools with bowel sounds active in all four quadrants, soft non-distended abdomen, with slight tenderness on palpation. The Physician responded with an order of Immodium AD one capsule by mouth after a loose stool up to four doses in twenty-four hours for two weeks, then discontinue. The COMMUNICATION-with Physician note dated 6/8/20 at 8:58 AM explained the facility received a fax back about the resident's loose stools. Received a new order for [MEDICATION NAME] AD one capsule with loose stools up to four doses in twenty-four hours for two weeks and then discontinue. The Health Status Note dated 6/8/20 at 1:35 PM explained the staff reported the resident with two loose stools that shift. The resident's [MEDICATION NAME] was ordered from the pharmacy. The resident's VS were temperature of 97.4, a pulse of 80, respirations of 16, and SpO2 of 95. The resident up per usual. The staff reported the resident with a decreased appetite. The Health Status Note dated 6/9/20 at 5:23 AM showed the resident had one small loose stool that shift. The resident slept good with no complaints, signs, or symptoms of discomfort. The Health Status Note dated 6/10/20 at 1:32 AM showed the resident had extreme abdominal distention with complaints of pain when checking for bowel sounds. The bowel sounds showed active upper quadrants, with no audible sounds on the lower right quadrant and hypoactive (slow) sounds on the lower left side. The SpO2 was 94% on room air and temperature of 97.8. The resident's heart rate was 78. The resident was lying on the left side. The CNA's were concerned for several days of the resident's change in condition. The Health Status Note dated 6/10/20 at 2:37 AM explained that after evaluation by the east side, Registered Nurse (RN) confirmation received that bowel sounds were very hypoactive on the left lower quadrant with none on the right lower quadrant. Pain medication given at 6:00 PM kept her comfortable at the time. At 6:00 AM, planned to confirm with the DON and recommend the resident be sent to the emergency room (ER). The Health Status Note dated 6/10/20 at 7:46 AM documented the night shift nurse reported a change with the resident during the morning report. The night shift nurse said the resident with a distended abdomen, hypoactive bowel sounds, and the loose stools. The resident had loose stools over the last few days, in which an [MEDICATION NAME] order was received. The resident continued to have loose stools on and off. It was reported the resident with a decreased appetite. The nurse worked with the resident on and off. The resident was having all of the above on and off in the time the nurse worked with the resident. The resident now complained of pain with palpation of the abdomen. The resident left the facility with staff. A copy of the Medication Administration Record [REDACTED]. The COMMUNICATION - with Resident note dated 6/10/20 at 2:15 PM showed the facility received a report from the RN at the hospital. The resident was admitted for UTI and [MEDICAL CONDITION] with plans to get intervenous (IV) [MEDICATION NAME] for two days then the resident would return by the weekend. The History and Physical dated 6/10/20 showed the resident admitted due to abdominal pain and dysuria at the skilled nursing facility (SNF). The impression and plan showed [MEDICATION NAME] [DIAGNOSES REDACTED]. The resident had the additional [DIAGNOSES REDACTED].

The Hospital Progress Note dated 6/10/20 showed the resident's chief complaint was abdominal pain, [MEDICATION NAME], Diabetes Mellitus type 2, bacteremia, hypomag (low magnesium), and dementia. The resident appeared to be tired and weak. The Admission Summary dated 6/12/20 at 3:10 PM documented the resident arrived from the hospital via the facility van due to [MEDICATION NAME], diverticulitis, and UTI symptoms. The Clinical Summary dated 6/12/20 showed the resident with [DIAGNOSES REDACTED]. The Health Status Note dated 6/14/20 at 1:27 PM explained a follow-up to the antibiotic therapy. The resident had loose stools that shift with a good appetite at meals-a PRN Immodium given for relief. The Hospital Discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	1037 19TH STREET SW MASON CITY, IA 50401

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 -** Actual harm **Residents Affected -** Few	(continued... from page 7) Notification signed by the Physician on 6/30/20 showed the resident's hospital [DIAGNOSES REDACTED]. The Physician Notification on 6/30/20 showed a request for Immodium due to the resident having loose stools. The provider responded on 6/30/20 with an order for [REDACTED]. After supper, the resident asked to go to the restroom and had difficulty with going. The urine observed in the toilet was cloudy; the nurse couldn't tell if there was an odor to it at the time. The resident was afebrile. A fax was sent to the Physician, awaiting a response. The Health Status Note dated 8/10/20 at 10:34 PM added an addendum to the previous note: The CNA reported the burning with urination was going on for two weeks. The burning was previously reported, and the nurses were pushing fluids. This week resident was in tears while urinating. The COMMUNICATION-with Physician dated 8/11/20 at 3:18 PM indicated the facility received a fax back from the doctor informing the resident of burning with urination for two weeks. The Dr. ordered a urine specimen by catheter for urinalysis (UA) with culture and sensitivity (C&S), Push oral fluids, [MEDICATION NAME] 500 mg one tablet by mouth twice daily for five days after the urine collection. Then get a urine specimen via catheterization for UA with C&S 48 to 72 hours after the antibiotic was completed. The Clinical Laboratory reported collected on 8/11/20 showed the urinalysis routine, noting the amber color's catheterized urine with turbid clarity. The urine was negative for [MEDICATION NAME] and showed one plus (+) glucose level with an expected level of negative. The urine had >100 white blood cells and 2+ of protein stix with an anticipated negative level. The Health Status Note dated 8/13/20 at 1:20 AM documented return fax received from the UA with lab results, awaiting final results with culture. The COMMUNICATION-with Physician note dated 8/13/20 at 4:48 PM explained the facility received a fax back on the UA with C&S. The fax sent back to the Dr. with the final specimen results, awaiting a response for treatment. The Clinical Laboratory report with a collection date of 8/11/20 showed a catheterized urine specimen with >100,000 colony-forming [DIAGNOSES REDACTED] pneumoniae and >100,000 colony-forming streptococci beta-[DIAGNOSES REDACTED] group B. The provider responded on 8/14/20 to change [MEDICATION NAME] to Bactrim DS one tablet twice daily for five days. The COMMUNICATION-with Physician note dated 8/14/20 at 9:05 AM documented new orders received from the provider to discontinue the [MEDICATION NAME] and start Bactrim DS twice daily for five days. The COMMUNICATION-with Physician note dated 8/14/20 at 5:20 PM explained the facility received a fax back from the provider for the Dr. with new order for Bactrim DS 1 tablet twice daily for five days due to a rash from the [MEDICATION NAME]. The Health Status Note dated 8/19/20 at 1:46 PM showed the last dose of antibiotics given that morning with scheduled medications. The resident was afebrile and stated the burning with urination was better. The urine odor and color with some improvement. A follow-up UA was scheduled four 48 to 72 hours. The Health Status Note dated 8/19/20 at 5:40 PM, labeled as a late entry, showed the resident had the last dose of antibiotics that morning. The resident had no complaints of pain or discomfort. The Orders - Administration Note related to the follow-up catheterization UA dated 8/21/20 at 8:00 PM explained the resident was up on the shift and not in bed from 2:00 PM until 7:00 PM. The Orders - Administration Note related to the follow-up catheterization UA dated 8/23/20 at 2:24 PM showed the UA was unable to obtain that shift. The Orders - Administration Note related to the follow-up catheterization UA dated 8/23/2020 at 9:00 PM showed a straight catheter collected the UA with one attempt. The COMMUNICATION-with Physician note dated 8/25/20 at 1:16 PM explained the facility received a fax back from the Dr. regarding the UA and C&S collected on 8/23/20, ordered to await the C&S results. The Urinalysis Routine collected on 8/23/20, noted by the facility on 8/25/20, showed the urine with a yellow, cloudy appearance with > 100 white blood cells. The Physician responded on 8/25/20 to await the culture and sensitivity report. The Urine Culture Lab collected on 8/23/20 returned from the Physician on 8/26/20, showed the Physician indicated no treatment need, and to discontinue the Bactrim if not finished. The culture showed no growth. The Care Plan problem dated 4/01/20 showed the resident at high risk for falls related to confusion, dementia, history of falls, incontinence, and psychoactive drug use. The intervention dated 4/1/20 said to offer routine toileting as the resident was incontinent of urine and has a history of UTI's. The resident did not always voice toileting needs. The resident was an assist of one with a gait belt for toileting. The Care Plan problem dated 3/31/20 said the resident had a UTI and was taking an antibiotic. The interventions dated 4/1/20 1. To encourage adequate fluid intake. 2. Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. 3. Monitor, document, and report to the Dr. PRN for signs and symptoms of a UTI such as frequency, urgency, malaise (weakness), foul-smelling urine, dysuria, fever, nausea, vomiting, flank pain, supra-pubic pain, hematuria (blood in urine), cloudy urine, altered mental status, loss of appetite, and behavioral changes. 4. Obtain and monitor lab or diagnostic work as ordered. Report results to the Dr. and follow up as indicated. The Care Plan problem dated 4/1/20 said the resident had [MEDICAL CONDITION] stage two. The resident had urinary incontinence with a history of UTI's. The interventions dated 4/1/20 1. Ensure thorough pericare and incontinence cares as the resident couldn't do themselves. 2. Monitor, document, and report for signs and symptoms of acute failure: Oliguria (urine output less than < 400 milliliters ml per 24 hours). Increased kidney labs (BUN and Creatinine). In the Diuretic phase (output >500 ml in 24 hours), the BUN and Creatinine level out. 3. Monitor, document, and report to the Dr. PRN for signs and symptoms of a UTI such as frequency, urgency, malaise, foul-smelling urine, dysuria, fever, nausea, vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, and behavioral changes. 4. Offer routine toileting as the resident does not always alert staff of the need to urinate. The resident's record lacked bowel and bladder assessments. Interviews On 8/20/20 at 11:05 AM, Staff B, Certified Nurses' Aide (CNA), reported taking the resident to the bathroom, and the resident had a burning sensation. Staff B said they told Staff A, Licensed Practical Nurse (LPN), about the burning sensation and saw Staff A write something up. Staff B reported this was the first time they saw someone write something up about it. Staff B said they had reported this before. Staff B was unsure how long the resident had the burning with urination, maybe a shift or day or so before that. Staff B said they have trouble reporting things and having some of the nurses follow-up on it. Staff B said they have never reported it to the Director of Nursing (DON) but knew another aide had many times to the DON. On 8/21/20 at 7:05 AM, Staff F, CNA, said they did not report the burning with urination as the other aides were reporting it for weeks. The nurses said to push fluids, but the resident was in tears when she went to the bathroom. Staff F said they weren't sure who reported it. Staff F said they don't feel like the nurses pay attention to the residents. Staff F said they don't think the nurses like when they report things. On 8/20/20 at 11:27 AM, Staff A, Licensed Practical Nurse (LPN), said that staff reported the resident was having problems with urination, so Staff A sent a fax to the Physician right away. Staff A said there is a possible barrier due to some nurses having issues with some of the aides. On 8/24/20 at 3:15 PM, Staff C, LPN, reported the resident had burning off and on. The burning was reported to the Physician. Staff C said they didn't learn of the burning until after the Physician gave orders. On 8/24/20 at 1:07 PM, Staff E, CNA, said the resident had trouble going to the bathroom. The resident had difficulty with their bowel movements as for a while; they were all watery, not formed, or normal. The nurses were aware of the burning with urination since the resident was admitted to the facility. The nurses were going to the cath the resident but didn't but not sure why. On 8/25/20 at 8:48 AM, Staff K, CNA, explained the resident had burning off and on a lot. Staff K said they always reported this to the nurse since the resident first came. The resident even went to the hospital once for something in their belly. Staff K stated they never had a problem with the nurses not listening. Often, the nurses say to push fluids for the resident as it was a reoccurring problem. On 8/25/20 at 9:41 AM, Staff H stated they told Staff C the resident had burning while peeing. Staff H was told to push fluids or cranberry juice. The resident started to cry and the nurse appeared not even to care. Staff C is the one nurse that if something is reported to, Staff C does nothing about it. Staff H doesn't know why Staff C isn't charting things when they are reported. On 8/25/20 at 2:36 PM Staff R, LPN, said the resident had problems with UTIs off and on multiple times. Staff R was unsure if the CNAs reported the concern with burning to anyone. If Staff R got a complaint, they would document it and then report it to the next shift coming on. Staff R said that sometimes things change from one shift to another. Follow-up interviews On 8/26/20 at 1:20 PM, the DON said if a resident was having burning with urination, the expectation was to do an assessment and push fluids using nursing judgment. If this did not help the resident, the nurse could collect urine as a physician's orders [REDACTED]. If the interventions did not help, the nurse should notify the Physician either by calling or faxing them. If the resident had a history of [REDACTED].
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure nursing staff knew how to complete a scheduled treatment to manage a pressure ulcer for one of two residents reviewed (Resident #2). The facility reported a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	1037 19TH STREET SW MASON CITY, IA 50401

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 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) census of 74. Findings include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 8/13/20 showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident admitted to the facility on [DATE] with a stage IV pressure ulcer. The resident required pressure ulcer care. The resident had a pressure-relieving device in the bed and chair. The resident required extensive assistance of one staff with bed mobility, dressing, transfers, and toileting during the seven day lookback period. The resident exhibited no instances of rejection of care during the seven day lookback period. The resident showed verbal and other behaviors for one to three days in the last seven days in the lookback period. The resident used opioids for seven of seven days of the lookback period. The resident was always incontinent of bowel and bladder in the seven day lookback period. The resident had [DIAGNOSES REDACTED]. Record review The Wound Care Skin Integrity Evaluation dated 8/10/20 showed the resident had a Stage IV pressure ulcer that began on 2/19/20. The wound had moderate exudate with a size of 4.00 by (x) 4.40 centimeters (cm) with a depth of 2.8 cm. The resident had a Pressure Ulcer Scale for Healing (PUSH) Score of 13.00. The wound had no tunneling but had undermining. The undermining was 0.6 cm from nine o'clock to eleven o'clock and one o'clock to three o'clock. The wound had [MEDICAL CONDITION] drainage. The wound bed was 80 percent (%) red of pink/red granulation with 20% bone. The peri-wound tissues were indurated and firm. The wound edges or margins were epiboly or rolled edges. The wound exhibited no pain to the resident. The clinical rationale indicated that an antimicrobial hydrogel gauze provides low adherent surface and provides sustained antimicrobial action to the wound. Collagen stimulates the growth of the granulation tissue. The bordered hydrogel dressing to sustain a moist wound environment promotes autolysis (breakdown of all or part of a cell or tissue by self-produced enzymes) and moist wound healing. Daily dressing changes are needed due to the dressing becoming dislodged within 24 hours due to moisture and incontinence. The treatment intervention was to cleanse the sacral wound per the facility protocol. Then apply sorbact gauze to the wound and fill the wound with layered collagen (use the full sheet). Complete by covering with bordered hydrogel dressing. Change the dressing daily and as needed (PRN). May initiate the treatment upon delivery of supplies. The Medication Administration Record [REDACTED]. Then apply a sorbact gauze to the wound. Next, fill the wound with a layered collagen sheet (use a full sheet.) Complete by covering with a bordered hydrogel dressing. Change dressing daily and as needed (PRN). May initiate the treatment upon delivery of the supplies. Do the treatment in the afternoon for a Stage IV pressure ulcer full-thickness wound with a start date of 8/19/20. The Care Plan problem dated 8/12/20 said the resident had a sacral pressure ulcer related to immobility due to MS. The intervention dated 8/12/20 indicated to administer treatments as ordered and monitor for effectiveness. The intervention dated 8/12/20 said to educate the resident, the family, and the caregivers about skin breakdown causes, including transfers, positioning requirements, the importance of taking care during ambulation, mobility, good nutrition, and frequent repositioning. Observation On 8/24/20 at 4:41 PM, observe Staff A, Licensed Practical Nurse (LPN), completed the dressing change on the resident's coccyx with the assistance of Staff E, Certified Nurses' Aide (CNA). After providing perineal care, Staff A removed gloves and applied new gloves without hand hygiene. Staff A touched the backside of the resident, then opened the package of gauze and other dressings. Staff A reported not knowing how to complete the new dressing change. Staff E rolled the resident to allow Staff A to see the wound. Staff A sprayed wound cleanser into the wound, wipes away the wound cleanser, sprayed more wound cleanser into the wound. Staff A wiped away the wound cleanser with new gauze. Staff A inserted a dressing into the wound while saying this piece is supposed to go first. Then bunches up sheets of collagen; Staff A said I hope this was right, I don't know how to do this. Then pushed the bunched sheet of collagen into the wound. Staff A then said this is supposed to go on the outside while holding another dressing. The dressing showed a number one on the outside. Staff A removed the paper on the dressing on the other side of the dressing. Attempted to place onto the resident, then removed the paper on the side with the number one. As Staff A continued to try to place over the wound, the dressing began to roll. Staff A removed gloves while stating no one knew how to complete the dressing and reported they were unsure if dressing was done right. Then Staff A explained to the resident that she would have to get the Director of Nursing (DON) to help finish the dressing. Interviews On 8/26/20 at 1:45 PM, the DON said the dressing was new, and they were all learning how to do it.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to use appropriate infection control techniques. The facility reported a census of 74. Findings include: On 8/19/20 at 12:57 PM, observed Staff T, Certified Nurses' Aide (CNA), walking a resident. Staff T was wearing a face mask appropriately but was wearing the face shield upside down on their head. The face shield did not cover any part of the face. On 8/19/20 at 2:46 PM, observed Staff G, CNA, and Staff H, CNA, complete perineal care on Resident #3. Staff H removed wipes from the package after wiping the resident with used gloves three times after the container's initial removal. Staff G stood helping to position the resident without assisting Staff H with the wipes. Staff H removed gloves, and without hand hygiene, rolled the resident towards Staff H while Staff G removed gloves and placed the new clean brief under the resident. The wipes lie on the bed under the resident's pressure reduction boots. Staff H without gloves or hand hygiene moved the wipes to the dresser with wipes remaining open with wipes hanging out of the package. On 8/19/20 at 2:57 PM, Staff S, CNA, sat with the resident in the living room area of weather b way with a mask on appropriately but without a face shield holding hands. On 8/19/20 at 2:59 PM, noted room [ROOM NUMBER] with an airborne and contact precautions sign on the door. Resident #7 was seen walking in the living room and hallway area without a face mask. Staff G entered the room wearing only a face mask and face shield, got clothes out of the closet and dresser. Staff H then got a blanket from the room and covered a resident in a recliner. On 8/20/20 at 8:45 AM, observe Staff I, CNA, assisting Resident #2 by handing the resident a washcloth and then taking the resident outside to smoke. Staff I initially observed without a face shield on the face and face mask pulled below the chin while giving the resident the washcloth. Once, Staff I saw the surveyor; Staff I pulled the face mask up over the mouth, exposing the nose without completing hand hygiene. On 8/20/20 at 9:11 AM, observed isolation gowns hanging from the door. No labels were noted near the gowns. On 8/20/20 at 12:30 PM, saw Staff Q, CNA, in room [ROOM NUMBER]. The door had a sign with airborne and contact precautions with biohazard bags in the room. Staff Q was talking to the resident wearing a face mask and face shield. Staff Q observed to be standing less than six feet in distance to the resident while holding an isolation gown over their arm. Staff Q exited the room and hung up the isolation gown on the door with no hand hygiene. On 8/20/20 at 12:33 PM, watched Staff L, CNA, walk out of room [ROOM NUMBER] after helping a resident with no face shield on and face mask down, exposing their nose, and placing a mechanical stand near the door in the hallway. On 8/20/20 at 12:35 PM, Staff L helped a resident walk to the shower room wearing a face mask and no face shield. On 8/20/20 at 12:45 PM, Staff M, CNA, stood resident in room [ROOM NUMBER] with no face shield and face mask, exposing their nose with mouth covered. On 8/20/20 at 12:50 PM, Staff P, CNA, pushed Resident #2 in a wheelchair out to smoke with a face mask covering mouth but exposing nose with a face shield. On 8/20/20 at 12:54 PM, Staff J, Registered Nurse (RN), explained that isolation gowns were reused without cleaning even disposable gowns. On 8/24/20 at 9:35 AM, observed a therapist working with a resident that was coughing. The resident did not have a face mask on, and the Therapist only wore a face mask. The Therapist was not wearing a face shield and was closer than 6 feet in distance to the resident. On 8/24/20 at 3:26 PM, Staff E, CNA, pushed Resident #2 out to their room with a face mask but no face shield. On 8/24/20 at 3:26 PM, Staff E worked with Resident #7 wearing only a face mask covering nose and mouth. On 8/24/20 at 3:26 PM, Staff A, LPN, worked with Resident #8, completing the vital signs. Staff A wore a face mask appropriately without a face shield or goggles. Staff A took the resident's orthostatic blood pressures and the resident's oxygen saturation. Staff A placed the pulse oximeter in their pocket without cleaning. On 8/24/20 at 3:32 PM, Staff A exited Resident #8's room after completing the resident's orthostatic blood pressure. Placed the blood pressure cuff and pulse oximeter on the cabinet, no barrier and without cleaning. On 8/24/20 at 3:34 PM, Staff A, while preparing the treatment supplies for Resident #2, Staff A touched their face mask, continuing the task without hand hygiene. On 8/24/20 at 3:41 PM, Staff A completed Resident #2's dressing with no face shield through the entire process. At 4:41 PM, Staff A finished by covering Resident #2 with a warm blanket, still without a face shield. On 8/25/20 at 1:19 PM, Staff U, LPN, entered room [ROOM NUMBER] wearing a face shield and face mask appropriately. Staff U took the isolation gown off the hook on the door without a label and placed already tied isolation gown over the head. Staff U then sanitized hands and shut the resident's door. Interviews On 8/26/20 at 1:15 PM, the Infection Preventionist reported that staff was to wear a face mask and a face shield while providing care. If the resident was on isolation, the staff should wear full personal protective equipment (PPE). If a staff member was doing a dressing change, the staff member should be wearing a face mask and a face shield. On 8/26/20 at 1:20 PM, the Director of Nursing (DON) said the expectation was the reusable isolation gowns should be changed every shift, and they should not use for more than one staff. Ancillary staff, such as therapy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
I O O F HOME AND COMMUNITY THERAPY CENTER	**1037 19TH STREET SW MASON CITY, IA 50401**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) were to wear disposable gowns. Yes, they are to reuse due to the shortage of disposable gowns. A sticky note should be placed above the hooks to indicate one for the nurse and one for the CNA. Record review The note labeled From Our Emergency Preparedness Coordinator dated 7/14/20, said the minimum PPE required throughout the facility was 1. A procedural mask for all staff members. Homemade masks can be worn outside of the procedural mask if you choose, but a homemade is not sufficient on its own. 2. Face shields should be worn by anyone in direct contact or cares with residents. The measure is going beyond the eye protection that safety glasses provide. The use of face shields includes but is not limited to nursing staff, dietary, and therapy staff. 3. In isolation or quarantine rooms, please follow the guidelines posted on the door. Do not forget to wear your facemask, face shield, gown, and gloves.