STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165578	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF MUSCATINE	**3440 MULBERRY AVENUE MUSCATINE, IA 52761**

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

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to document family notification for 2 of 4 residents in the standard sample of residents currently residing in the facility (Residents #1 and #2). The facility reported a census of 70 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) quarterly assessment completed 6/12/20 documented the following Diagnoses: [REDACTED]. It also identified the resident as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 10 out of 15, required extensive staff assistance with most activities of daily living and had one stage II facility acquired pressure ulcer. The MDS Admission Assessment completed 4/13/20 revealed the resident did not have any pressure ulcers upon admission to the facility. A review of weekly skin assessments revealed the following: a. On 5/18/20 left heel with blister which measured 6 cm(centimeters) long, 5 cm wide. b. On 5/25/20 left heel pressure wound is now open where wound bed can be seen. Majority of skin covering wound still intact. Wound bed is pink with areas of redness. No drainage or odor or increased heat. Measured 6.7 cm long and 7.5 cm wide with no depth recorded. c. On 6/1/20 left heel with opened blister 7 cm long and 5 cm wide, red and dark brown in wound bed with parameter peeling. d. On 6/17/20 left heel with deep tissue wound black in color with slight bleeding on edges, no drainage and measured 3.1 cm long and 3.3 wide. A review of the only completed Pressure Injury Weekly Assessment completed on 5/25/20 revealed the following: The resident developed a facility acquired pressure injury Stage II to the left heel which measured 6.7 cm long, 7.5 cm wide and had no depth, exudate (drainage), or odor. The wound bed appearance had skin peeling away, wound underneath is pink, surrounding skin color is pink and surrounding tissue/wound edges pink with areas of red. The name of responsible party notified marked as N/A as the resident had been her own responsible party. The Care Plan identified the resident with the problem of impairment to skin integrity related to wounds to the right leg on 4/9/20. The Care Plan revised last on 6/25/20 and directed the staff to follow these interventions: a. Monitor/document location, size and treatment of [REDACTED]. to the doctor. b. She needs pressure relieving/reducing cushion to protect the skin while up in the chair. c. She needs pressure relieving/reducing mates to protect the skin while in bed. d. Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Review of physician orders revealed the following: a. On 4/13/20 complete weekly skin assessment. b. On 6/12/20 Left Heel: Apply [MEDICATION NAME] to entire wound and periwound. Allow to dry and then wrap heel with fluffed kerlix. Do not allow wound to become wet. c. On 6/22/20 OK to test for COVID-19. d. On 6/30/20 OK to transfer to nursing home in(NAME) IA on 7/1/20. A review of the nurse's notes revealed the following: a. On 5/18/20 3:17 p.m. no signs or symptoms of infection present, wound bed beefy pink with flecks of yellow (no documentation of location of the wound or notification of family of new wound identified). b. On 5/25/20 1:30 p.m. left heel pressure wound is now open where the wound bed can be seen, majority of skin covering wound still intact. Wound bed is pink with areas of redness. There is no drainage or odor or increased heat, measured 6.7 cm long and 7.5 cm wide. (no documentation of notification of family). c. On 5/28/20 1735 received new orders from Physician to discontinue the current wound dressings and cover the right heel with [MEDICATION NAME] Blue and secure with [MEDICATION NAME] tape, wrap with kerlix, change every other day and keep heels floated at all times. (no documentation of notification of family). d. On 6/22/20 1:25 p.m. OK to test for COVID-19 per primary care physician. Notes after 6/22/20 did not have documentation to show the COVID-19 test had been completed and results reported to family. During an interview on 7/1/20 at 9:52 a.m., Staff A, Licensed Practical Nurse (LPN) reported when a new pressure ulcer is identified, the nurse should notify the family, physician and Director of Nursing (DON) and document as completed in the nurse's progress notes. In an interview on 7/1/20 at 4:17 p.m., Staff B, LPN reported when a new pressure ulcer is identified, the nurse should notify the family in the nurse's notes on the day it is found. During an interview on 7/2/20 9:36 a.m., Staff H, Registered Nurse (RN) reported when a new pressure ulcer is identified, the nurse who found it would notify the physician immediately and notify the family and DON within 24 hours. This would be documented in the Nurse's Notes, or Weekly Skin Assessment and Incident Report. In an interview on 7/2/20 11:41 a.m., the DON reported upon finding a new pressure ulcer, she would expect the nurse to notify the physician and family and document this in the Nurse's Progress Notes. A review of the facility policy titled: Skin Care and Wound Management with the original date of June 2015 documented Staff should communicate risk factors and interventions to the resident and/or family/responsible party and communicate changes to the resident and/or family/responsible party. 2. Resident #2's MDS annual assessment completed 4/28/20 documented the following Diagnoses: [REDACTED]. It also identified the resident with a BIMS score of 12 out of 15 and independent with most activities of daily living. A review of the Physician Orders revealed an order dated 6/22/20 to test for COVID-19. A review of the Care Plan identified the resident with the problem of being at risk for alteration in psychosocial well being related to restriction on visitation due to COVID-19 initiated on 3/12/20. The interventions did not include notification of family with COVID-19 test results. A review of the nurse's notes revealed the following entries: a. On 7/1/20 at 10:21 p.m. that resident had COVID-19 test results negative. (No documentation of notification of family). b. On 7/5/20 8:43 p.m. doctor notified of negative COVID-19 test results (No documentation of notification of family). During an interview on 7/1/20 4:17 p.m., Staff E, LPN reported the nurse should notify the family when a COVID-19 test is completed and document this in the Nurse's Progress Notes. In an interview on 7/6/20 9:03 a.m., Staff A, LPN reported the nurse who received the COVID-19 test results should contact the family and document that in the Nurse's Progress Notes, however, admitted she had not always notified family as she would forget. During an interview on 7/6/20 9:13 a.m., Staff J, LPN reported the nurse should notify the physician, family and DON of any COVID-19 test results and document this in the Nurse's Progress Notes. In an interview on 7/6/20 12:14 p.m., the Nurse Consultant reported the facility did not have a policy on family notification specific to COVID-19 test results, that they follow the Centers for Medicare & Medicaid Services (CMS) guidelines.
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 record review, resident and staff interviews, the facility failed to administer medications as ordered by the physician for one of six residents in the standard sample (Resident #6). The facility reported a census of 70 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) Admission Assessment completed 3/15/20 documented the following Diagnoses: [REDACTED]. It also identified the resident required extensive staff assistance with most activities of daily living. During an interview on 6/30/20 at 1:32 p.m., the Nurse Consultant reported she could not find a Care Plan for the resident for this admission. A review of the Physician Orders and March 2020 Medication Administration Record [REDACTED]. ASA (aspirin) 325 mg (milligrams) one tablet BID (twice daily) on 3/14/20 on evening shift. b. [MEDICATION NAME] (treats depression) 60 mg BID on 3/13/20 on evening shift and on 3/14/20 on evening shift. c. [MEDICATION NAME] (treats pain and inflammation) 75 mg BID on evening shift on 3/13/20 and 3/14/20. d. [MEDICATION NAME] (treats pain) 200 mg one tab BID on

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) evening shift on 3/14/20. e. [MEDICATION NAME] (treats diabetes) 1000 mg one tab BID on evening shift on 3/13/20 & 3/14/20. f. Senosides (for constipation) 8.6 mg two tabs BID on evening shift 3/14/20 (was signed out for evening shift 3/13/20). g. [MEDICATION NAME] (for asthma/[MEDICAL CONDITION]) aerosol 160-4.5 mcg/ACT 2 puffs BID on evening shift 3/14/20. h. [MEDICATION NAME] (antibiotic) 1000 mg per 10 ml, give 200 ml IV BID on evening shift on 3/14/20. i. [MEDICATION NAME] HFA (for asthma/[MEDICAL CONDITION]) aerosol solution 108 mcg/ACT 2 puffs BID on evening shift on 3/13/20 and 3/14/20. A review of the list from the Pharmacy showed the following medications returned to the Pharmacy and only one tablet/capsule given for the following: a. Atorvastatin calcium (treats high cholesterol) 40 mg. b. Duoxetine ([MEDICATION NAME]) 60 mg. c. Buproprion XL (antidepressant). d. [MEDICATION NAME] 1000 mg. During an interview on 7/2/20 at 10:40 a.m., the Pharmacy Manager reported the other medications should have been removed from stock medications kept at the facility. The IV (intravenous) medications were sent to the facility, however, unable to be returned to the pharmacy. A review of the Nurse's Progress Notes revealed the following: a. On 3/13/20 at 4:39 p.m. admitted female with the [DIAGNOSES REDACTED]. The resident is continent of bowel and bladder but has accidents at night at times. b. On 3/15/20 at 7:15 a.m. Last entry in Nurse's Notes. c. At 10:15 p.m., nurse went into the room to inform her that Pharmacy had not been there yet, but would be there. The resident started crying and yelling that the facility was so incompetent and she had called her boyfriend to get her that she was not staying there. Attempted to de-escalate the situation by apologizing, resident did calm down. d. At 10:30 p.m. the pharmacy arrived with [MEDICATION NAME] and [MEDICATION NAME] which the resident took. The resident signed the Against Medical Advice (AMA) form, had planned to return to the hospital and did not want to stay to receive the IV antibiotic. e. At 00:11 a.m. the resident left with her boyfriend after nurse and Certified Nurse Aide (CNA) assisted her into the vehicle. During an interview on 7/1/20 at 9:52 a.m., Staff A, Licensed Practical Nurse (LPN) reported if a resident is admitted in the afternoon, the nurse would need to call the Pharmacy before 6:00 p.m., otherwise medications will not arrive until the next day. If the resident needs medications right away, the pharmacy will contact a local pharmacy for medications we do not stock here. In an interview on 7/1/20 at 4:17 p.m., Staff E, LPN reported if a resident is admitted in the afternoon, she would enter the orders in the computer and call the Pharmacy immediately to ensure medications arrive that day. If the resident needed something immediately, she would remove medications out of the emergency box or let the Pharmacy know then they would contact the local Pharmacy here. During an interview on 7/1/20 at 4:59 p.m., Staff G, Licensed Practical Nurse (LPN) reported when this resident had been admitted in the late afternoon and the resident reported she did not receive her medications. When a resident is admitted in the afternoon, the nurse should fax the orders to the Pharmacy. If there are medications needed right away, they can be obtained from a local Pharmacy here. In an interview on 7/2/20 at 9:36 a.m., Staff H, RN (who took care of the resident prior to leaving AMA) reported if a resident is admitted in the afternoon, the nurse would have to contact the Pharmacy before 5:00 p.m. If there are medications needed earlier, there are medications the facility has stocked and there is a local Pharmacy that could send those medications needed. She also reported the night the resident signed out AMA, the resident reported it had been 3 or 4 days before she got her medication. She had orders for IV antibiotics that Staff H wanted to administer and the resident refused, she was so upset about not getting her other medications. During an interview on 7/2/20 at 11:41 a.m., the Director of Nursing reported not familiar with the facility policy as she had just been employed a week, but would expect nurses to administer evening medications for new residents admitted in the afternoon. She would expect the nurses to check all MAR's to ensure all medications were given and signed out. A review of the facility policy titled: Medication Management with the original date of May 2014 revealed the following documentation: a. Medications are administered in accordance with the residents' plan of care and all efforts are made to prevent medication errors. b. A medication error is any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professionals, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing; order communication' product labeling, packaging and nomenclature; compounding; dispensing; distribution, administration; education; monitoring and use. c. Omission error is identified as the failure to administer an ordered dose to a resident by the time the next dose is due, assuming there has been no prescribing error. Exceptions would include a resident's refusal to take the medication and failure to administer the dose because of recognized contraindications.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to provide complete documentation of for one of one residents identified with pressure ulcers (Resident #1) The facility reported a census of 70 residents. Findings include: 1. The Minimum Data Set (MDS) Quarterly Assessment completed 6/12/20 documented the following Diagnoses: [REDACTED]. It also identified the resident as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 10 out of 15, required extensive staff assistance with most activities of daily living and had one stage II facility acquired pressure ulcer. The MDS Admission Assessment completed 4/13/20 revealed the resident did not have any pressure ulcers upon admission to the facility. A review of the Nursing Admission Data Collection Sheet completed 4/6/20 revealed the following: a. In Section J admission skin sweep to identify if skin impairments had been present had not been completed. b. The Braden Scale (An assessment tool used to identify the risk for pressure sores) score had not been completed. c. All [DIAGNOSES REDACTED]. On 5/18/20 left heel with blister which measured 6 cm (centimeters) long, 5 cm wide. b. On 5/25/20 left heel pressure wound is now open where wound bed can be seen. Majority of skin covering wound still intact. Wound bed is pink with areas of redness. No drainage or odor or increased heat. Measured 6.7 cm long and 7.5 cm wide with no depth recorded. c. On 6/1/20 left heel with opened blister 7 cm long and 5 cm wide, red and dark brown in wound bed with parameter peeling. d. On 6/17/20 left heel with deep tissue wound black in color with slight bleeding on edges, no drainage and measured 3.1 cm long and 3.3 wide. No further weekly skin assessments completed for the pressure ulcer to the left heel after 6/17/20. A review of the only completed Pressure Injury Weekly Assessment completed on 5/25/20 revealed the following: The resident developed a facility acquired pressure injury Stage II to the left heel which measured 6.7 cm long, 7.5 cm wide and had no depth, exudate (drainage), or odor. The wound bed appearance had skin peeling away, wound underneath is pink, surrounding skin color is pink and surrounding tissue/wound edges pink with areas of red. The care plan identified the resident with the problem of impairment to skin integrity related to wounds to the right leg on 4/9/20. The care plan had been revised last on 6/25/20 and directed the staff to follow these interventions: a. Monitor/document location, size and treatment of [REDACTED]. to the doctor. b. She needs pressure relieving/reducing cushion to protect the skin while up in the chair. c. She needs pressure relieving/reducing mates to protect the skin while in bed. d. Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. The Care Plan did not include the development of pressure ulcers identified to the heels. Review of physician orders revealed the following: a. On 4/13/20 complete weekly skin assessment. b. On 6/12/20 Left Heel: Apply [MEDICATION NAME] to entire wound and periwound. Allow to dry and then wrap heel with fluffed kerlix. Do not allow wound to become wet. c. On 6/30/20 OK to transfer to nursing home in(NAME) Iowa on 7/1/20. A review of the Nurse's Notes revealed the following: a. On 5/18/20 3:17 p.m. no signs or symptoms of infection present, wound bed beefy pink with flecks of yellow (no documentation of location of the wound or notification of family of new wound identified). b. On 5/25/20 1:30 p.m. left heel pressure wound is now open where the wound bed can be seen, majority of skin covering wound still intact. Wound bed is pink with areas of redness. There is no drainage or odor or increased heat, measured 6.7 cm long and 7.5 cm wide. c. On 5/28/20 1735 received new orders from physician to dc current wound dressings and cover the right heel with [MEDICATION NAME] blue and secure with [MEDICATION NAME] tape, wrap with kerlix, change every other day and keep heels floated at all times. A review of the Braden Scales revealed the assessments had been completed only on 4/6/20 with a score of 17 and 6/25/20 with a score of 15, which identified the resident as low risk. An observation of wound care on 6/30/20 at 9:47 a.m. revealed Staff A, Licensed Practical Nurse (LPN) and Staff K, Certified Nurse Aide (CNA) used proper infection control techniques and measured the necrotic area to the left heel as 5.2 cm long and 7.1 cm wide with no redness or drainage noted to surrounding skin. The left foot had 3+ [MEDICAL CONDITION]. During an interview on 7/1/20 at 9:52 a.m., Staff A, LPN reported she could not remember when the area to the left heel opened up, however, felt it had been caused by the resident's shoes which had been removed afterward. In an interview on 7/1/20 at 10:32 a.m., Staff B, CNA reported the resident had been compliant with repositioning and floating her heels and spent most of the day in the wheelchair with bunny boots to her feet. During an interview on 7/1/20 at 11:44 a.m., Staff C, CNA reported the resident usually slept during her shift and compliant with repositioning and floating her heels with bunny boots and pillow underneath her legs. During an interview on 7/6/20 at 9:41 a.m., the Staff I, Physician Assistant reported she had been first notified of the

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) pressure ulcer to the left heel on 5/14/20 and felt the area had been caused by pressure and that the ulcer could have been avoided. In an interview on 7/6/20 at 12:30 p.m., the Director of Nursing reported she would expect nurses to measure and assess wounds weekly and document either in the pressure injury notes or nurse's notes. A review of the facility policy titled: Skin Care and Wound Management with the original date of June 2015 directed the staff to take the following steps for prevention: a. Complete the Braden Scale on admission, weekly x 4 then quarterly to identify the resident pressure ulcer risk indicators. b. Complete the Admission skin sweep and the admission clinical information data collection and initial care plan on admission. Initiate the weekly skin sweep thereafter. Identify areas of skin impairment and any pre-existing signs. c. Determine the reason(s) a resident is at risk for pressure ulcer development. d. Develop a care plan with input from the interdisciplinary team and the resident and family/responsible party. Document individualized goals and interventions to manage risk factors. e. Communicate risk factors and interventions to the Care-giving team, resident and/or family/responsible party. f. Evaluate for consistent implementation of interventions and evaluate effectiveness of interventions during the care management meeting. g. Modify and document goals and interventions as indicated. h. Communicate changes to the Care-giving team, resident and/or family/responsible party.