STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165238	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DENISON CARE CENTER	**1202 RIDGE ROAD DENISON, IA 51442**

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to review and revise care plans in a timely manner for 1 of 5 residents reviewed (Resident #1). The facility reported a census of 30 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #1 required extensive assistance with the assistance of 2 staff for transfers, dressing, bathing and toileting. The MDS assessed the resident with a Brief Interview for Metal Status (BIMS) score of 9 out of 15 (moderate cognitive deficit). The MDS indicated that the resident had [DIAGNOSES REDACTED]. According to the resident census in the electronic chart, Resident #1 admitted to the facility on [DATE] and hosptalized on [DATE] with acute kidney failure and readmitted to the facility on [DATE] with a Foley urinary catheter in place. According to the nursing admission assessment dated [DATE] Resident #1 had no pressure ulcers upon admission. A skin assessment dated [DATE] identified the resident with a pressure ulcer of the right heel measuring 4.2 centimeters (cm) length x 5.4 cm width x 0 depth, and one on the left heel that measured 2.0 cm x 3.1 x 0. According to a physician's orders [REDACTED]. The order directed staff to insert a catheter as needed if the resident did not have any output for a 12 hour period. The care plan lacked focus areas and interventions to address the monitoring of urinary output or monitoring of foot ulcers. The care plan lacked details regarding the pressure ulcers on his feet and had no interventions related to pressure prevention. In an interview with the Administrator on 10/13/20 at 1:10 PM she said that they have been without a designated staff person to update care plans.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 ensure that all residents received treatment and care in accordance with professional standards and failed to provide professional nursing assessments and timely intervention for 4 of 5 residents reviewed (Resident #1, #2, #3, #4.) The facility reported a census of 30. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #1 required extensive assistance with the assistance of 2 staff for transfers, dressing, bathing and toileting. The MDS assessed the resident with a Brief Interview for Metal Status (BIMS) score of 9 out of 15 (moderate cognitive deficit). The MDS indicated that the resident had [DIAGNOSES REDACTED]. According to the resident census in the electronic chart, Resident #1 admitted to the facility on [DATE] and hosptalized on [DATE] with acute kidney failure and readmitted to the facility on [DATE] with a Foley urinary catheter in place. Nursing notes dated 9/14/20 at 12:10 PM indicated the resident readmitted to the hospital on [DATE] with foot ulcers and kidney failure. While at the hospital, he was admitted to Hospice services and returned to the facility on [DATE] on Hospice. According to the nursing notes the resident passed away on 9/18/20. A Braden Scale assessment (used to determine risk for development of pressure ulcers) completed on 9/12/20 and dated 7/11/20 identified the resident with no impairment in sensory perception or ability to respond meaningfully to pressure-related discomfort. The assessment indicated the resident did not have sensory deficits to limit his ability to feel or voice pain or discomfort. The chart lacked any follow up Braden Scale assessments until the resident returned from the hospital on [DATE] and on that date the assessment identified the resident at very high risk for development of pressure sores. A nursing admission assessment dated [DATE], identified the resident at mild risk for pressure development and at that time, the only skin issues recorded revealed bruising on the left elbow, right hand and left hand and discoloration to the right 3rd toe. A pressure injury weekly assessment form 7/18/20 identified an unstageable pressure area on the right heel measuring 4.2 centimeters (cm) length x 5.4 cm width x 0 depth. The left heel contained an unstageable pressure ulcer that measured 2.0 cm x 3.1 x 0. A third area identified as the outer left great toe revealed a 2.4 cm. by 2.5 cm. by 0 stage 1. A physician order [REDACTED]. According to a skin assessment dated [DATE], the left heel had healed and the right heel measured 3 cm x 3.5 cm. A skin assessment completed on 8/19/20 revealed an area discovered on the right great toe measuring 4.2 cm x 3.0 cm. From 8/26/20 until the resident's hospitalization on [DATE], the chart lacked measurements on any of the previously mentioned ulcers. According to a nursing note dated 9/17/20, when the resident returned from the hospital on [DATE] the right heel ulcer measured 4 cm x 3.5 cm, right great toe was 1 cm x 1.5 cm., and one additional ulcer on the side of the right great toe measured 2 cm x 1.5 cm x 0. According to a physician's orders [REDACTED]. The order directed staff to insert a catheter as needed if the resident did not have any output for a 12 hour period. According to the electronic documentation of output for the resident, on 9/8/20 and 9/12/20 the resident did not have any urinary output. The chart lacked any information regarding follow up on those two days with no documented urine output. An intake/output entry made on 9/15/20 at 1:00 PM revealed the resident ate 76%-100% of his breakfast meal, however the resident was in the hospital at that time. Nursing notes dated 9/14/20 at 12:10 p.m. revealed the resident admitted to the hospital. Nursing notes dated 9/17/20 revealed the resident readmitted from the hospital on [DATE] at 12:45 p.m. On 10/1/20 at 8:10 AM, Staff A RN (registered nurse) remembered providing care for Resident #1 and stated she assessed him upon admission on 7/4/20 and then again on 7/5/20 when he returned from the hospital. She said that in that one day he was a different person. Initially he had been very interactive and independent but after the hospital stay he slept more and his speech was slurred. She said that initially he was continent of bowel and bladder but was incontinent of both when he came back on the 5th. On 10/12/20 at 12:30 PM the doctor that treated Resident #1 during his hospitalization s, stated that he remembered the resident and stated the resident had a severe decline in health. The doctor said the resident had little feeling in his feet and due to his dementia the resident could not express his pain and discomfort. When asked about the [DIAGNOSES REDACTED]. hours without voiding. The doctor said he would have wanted to have been contacted if/when the resident went longer than 12 hours without voiding but he could not say for sure if that would have made a difference in the outcome due to the resident's total decline in health. 2. A MDS dated [DATE] assessed Resident #2 with a BIMS score of 0 out of 15 (severe cognitive impairment). The MDS revealed the resident admitted to the facility on [DATE]. The MDS identified, that upon admission, the resident required extensive assistance of 2 staff for bed mobility, dressing and toileting and required limited assistance two staff for transfers. A fall assessment completed on 4/6/20 at 10:05 AM, but dated 3/31/20 at 9:25 AM, revealed an unwitnessed fall on 3/31/20 at 9:25 PM. The facility contacted the family and physician. Nursing notes dated 3/31/30 identified the resident with complaints of lower back pain at 3:55 p.m. and Staff administered Tylenol ([MEDICATION NAME]). A later entry at 7:57 p.m. identified the Tylenol as effective. A pain evaluation completed on 4/6/20 at 2:53 AM, but dated 4/1/20 2:48 PM. identified the resident with severe pain at fracture site and a change in behavior. The pain evaluation

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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DENISON CARE CENTER	1202 RIDGE ROAD DENISON, IA 51442

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) form identified the resident with a [MEDICAL CONDITION] 2 and healing [MEDICAL CONDITION]. The chart lacked any documentation of physician notification until nurses notes revealed a notification on 4/5/20 at 5 p.m. A pain assessment dated [DATE] at 7:57 AM revealed the resident rated her pain at 6 out of 10 (with 10 being the worst imaginable pain). According to a nursing note on 4/2/20 at 6:18 PM, the resident refused her evening meal and on 4/3/20 at 1:05 PM she refused fluids. A nursing note dated 4/4/20 at 3:11 indicated the resident refused to eat and reported lower back pain. A nursing note dated 4/4/20 at 5:00 PM documented the nurse observed swelling to coccyx and lower lumbar and an unsteady gait. The nurse documented she notified the doctor at that time and the resident went to the emergency room (ER). According to the hospital documentation dated 4/5/20, the resident suffered a Lumber 2 fracture. The resident returned to the facility on [DATE] at 5:46 PM. On 10/1/20 at 3:15, Staff E CNA (certified nurse aide) revealed she and the nurse found the resident on the floor in the bathroom. She remembered the resident told them she did not have pain at that time but that a couple of times, days after the fall she said that her back hurt and Staff E noticed the resident walked slower slower. Staff E said she reported the pain to the nurses and assumed that they followed up. 3. An MDS dated [DATE] assessed Resident #3 with a BIMS score of 15 (no cognitive impairment) and [DIAGNOSES REDACTED]. The MDS indicated the resident required extensive assistance of two staff with bed mobility, and toileting and the resident required limited assistance of one staff with transfers, locomotion and hygiene needs. In a series of observation on 9/28/20 at 2:10, 3:30, 4:00 and 4:30, observation revealed the resident in the same position in bed on her back. According to meals eaten documentation on 9/28/20 at 10:55 AM and 1:40 PM the resident did not eat and at 6:43 PM for the evening meal it indicated that she was not available. The Fluids with Meals documentation on 9/28/20 at 10:58 AM and 1:22 PM indicated no fluid intake at the morning or lunch meal and the evening meal documented as not applicable at 9:26 p.m. A nursing daily skilled assessment dated [DATE] at 12:24 AM revealed the resident remained in bed the entire shift with good appetite and fluid intake. The assessment did not contain documentation of urine output. A nursing note dated 9/29/20 at 5:54 AM identified the resident as flushed and hot to touch. Vitals taken and found with a temperature of 103.4 degrees, heart rate (HR) 108, blood pressure 100/54 and oxygen saturation 90% on room air. The facility notified the physician and the resident transferred to the hospital. According to the ER report dated 9/29/20 at 7:14 AM the resident reported she felt ill for the previous 5 days and she admitted to the hospital with [REDACTED]. On 9/29/20 at 9:43 AM, Staff A, RN stated she provided care for the resident during the day on 9/28/20 and she did not notice anything different or concerning about the residents skin color, or any lethargy. Nursing documentation dated 9/28/20 at 6:37 PM identified the resident's appetite as good and fluid intake good and resident alert. In an interview on 9/29 at 10:04 AM Interview with CNA Staff E worked on 9/28 she that when she emptied the urine bag that day, she noticed the urine to be darker than normal. She noticed that the resident hadn't eaten much, and that normally she would eat almost all of what is put in front of her. CNA staff E said that she also worked on 9/27/20 and noticed that the urine was darker on that day and that the resident appeared to be sleepier. She said that she had reported to this to the nurse. In an interview on 9/29/ 10:15 AM, CNA Staff G said she had worked with Resident #3 on 9/28 and had noticed that the urine was a little dark with sediment and that the resident had been sleeping more than normal. She also stated that the resident would usually drink her entire pitcher of water before the end of the day, but on 9/28 the resident drank about half as much water. Staff G stated that the resident told her that she was not feeling well at supper time, and had an upset stomach. Staff G said that she reported to nurse that the resident wasn't herself. Staff G was unsure if there was any follow up from the nurse. 4. A MDS dated [DATE] assessed Resident #4 with a BIMS score of 15 out of 15 (no cognitive impairment). The resident had [DIAGNOSES REDACTED]. According to the MDS, the resident was independent with transfers, eating, toileting and bed mobility. Observation on 9/28/20 at 10:30 AM revealed the resident in his room in a wheel chair and appeared to be sleeping with a protective boot on his right foot and his left leg absent from above the knee. A skin assessment dated [DATE], revealed the resident had a non-pressure skin tear on the top of his left lower leg. Follow up skin assessments dated 9/15, and 9/29 also referred to a skin tear on the left leg. A follow up skin assessment on 10/6/20 indicated that this skin tear was on his right leg. Observation on 10/1/20 at 9:45 AM, showed Staff A RN provide treatment to a pressure area on the resident's toe. Staff A asked the resident when he had gotten the skin tear and stated this was the first time she observed it. According to the nursing notes, Staff A RN cared for Resident #4 on 9/24/20 and 9/29/20. On 10/13/20 at 2:40, the Administrator said Staff A did not work on the floor on 9/29/20 so would not have done patient cares. When asked about nurse to nurse report if she would expect new skin tear information passed on, she said she expected nurses would share it in report. According to the policy titled: Skin Care and Wound Management, staff are directed to identify residents at risk for developing pressure ulcers and implement prevention strategies to minimize the developing of pressures ulcers and skin integrity issues with weekly monitoring of skin status and daily monitoring of existing wounds.
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, clinical review and interview the facility failed to provide care to prevent the development and worsening of pressure ulcers for 2 of 5 residents reviewed (Residents #1 and #3). The facility reported a census of 30 residents. Findings include: 1. According to the Minimum Data Set ((MDS) dated [DATE], Resident #1 required extensive assistance with the assistance of 2 staff for transfers, dressing, bathing and toileting. The MDS assessed the resident with a Brief Interview for Metal Status (BIMS) score of 9 out of 15 (moderate cognitive deficit). The MDS indicated that the resident had [DIAGNOSES REDACTED]. A nursing admission assessment dated [DATE], identified the resident at mild risk for pressure development and at that time, the only skin issues recorded revealed bruising on the left elbow, right hand and left hand and discoloration to the right 3rd toe. A Braden Scale assessment (used to determine risk for development of pressure ulcers) completed on 9/12/20 and dated 7/11/20 identified the resident with no impairment in sensory perception or ability to respond meaningfully to pressure-related discomfort. The assessment indicated the resident did not have sensory deficits to limit his ability to feel or voice pain or discomfort. The chart lacked any follow up Braden Scale assessments until the resident returned from the hospital on [DATE] and on that date the assessment identified the resident at very high risk for development of pressure sores. A nursing admission assessment dated [DATE], identified the resident at mild risk for pressure development and at that time, the only skin issues recorded revealed bruising on the left elbow, right hand and left hand and discoloration to the right 3rd toe. A pressure injury weekly assessment form 7/18/20 identified an unstageable pressure area on the right heel measuring 4.2 centimeters (cm) length x 5.4 cm width x 0 depth. The left heel contained an unstageable pressure ulcer that measured 2.0 cm x 3.1 x 0. A third area identified as the outer left great toe revealed a 2.4 cm. by 2.5 cm. by 0 stage 1. A physician order [REDACTED]. According to a skin assessment dated [DATE] at 7:22 AM the left heel had healed and the right heel was 3 cm x 3.5 cm., and an area was discovered on the right great toe measuring 4.2 cm x 3.0 cm. A skin assessment dated [DATE] at 1:00 PM included the right heel measuring 3 cm x 3 cm and the outer great toe 2.5 cm x 2 cm. From 8/26/20 until the resident's hospitalization on [DATE], the chart lacked measurements on any of the previously mentioned ulcers. According to a nursing noted dated 9/17/20 at 1:00 PM, the resident returned to the facility with the following ulcers: Right heel 4 cm x 3.5 cm. side of the right great toe was 2 cm x 1.5 cm. and the top of the right great toe measured 1 cm x 1.5 cm. The care plan lacked focus areas and interventions to address the monitoring of foot ulcers. The care plan lacked details regarding the pressure ulcers on his feet and had no interventions related to pressure prevention. 2. A MDS dated [DATE] assessed Resident #3 with a BIMS score of 15 (no cognitive impairment) and [DIAGNOSES REDACTED]. The MDS revealed the resident required extensive assistance of two staff for bed mobility, and toileting. The resident required limited assistance of one staff for transfers, locomotion and hygiene needs. According to the care plan dated 2/5/20 the resident required assistance to reposition every two hours. Observation showed on 9/28/20 at 2:10 p.m., 3:30 p.m., 4:00 p.m. and 4:30 p.m., the resident in the same back lying position in bed at all observations. According to weekly pressure assessments dated 7/3/20 at 11:37 AM a chronic ulcer on the left gluteal fold measured 6.9 cm x 1.7 cm x 1.4 cm depth. On 8/19/20 it measured 4.4 cm x 1.8 cm x 0.1 cm. On 9/1/20 it measured 5.1 cm x 2.0 cm x 1.8 cm. The chart lacked any other measurements up until her hospitalization on [DATE]. According to a nursing note on 9/29/20 at 5:54 AM the resident appeared flushed and hot to touch. Staff obtained vital signs. The resident's temperature measured 103.4 degrees, heart rate 108, blood pressure 100/54 and oxygen saturation 90% on room air. Staff notified the physician and the resident transferred to the hospital. According to the emergency room report the resident reported that she felt ill for the last 5 days and she admitted to the hospital with [REDACTED]. Nursing notes dated 9/8/20 11:48 AM, 9/18/20 3:42 PM and 9/25/20 3:42 PM indicated that the resident refused one of the twice a day treatments to the wound. Nursing notes dated 9/18/20 3:42 PM and 9/25/20 3:42 PM indicated the resident refused skin assessment on those dates. The chart lacked documentation of any other attempts at assessment. According to the hospital records dated

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 9/30/20 at 8:35 AM the wound on bottom in left buttock crease measured 10 cm x 3 cm and observed a superficial small slit open area at the top of coccyx. On 10/13/20 at 1:15 PM the Administrator stated Resident #3 often refused cares and could change positions per self in bed. According to the policy titled: Skin Care and Wound Management, staff are directed to identify residents at risk for developing pressure ulcers and implement prevention strategies to minimize the developing of pressures ulcers and skin integrity issues with weekly monitoring of skin status and daily monitoring of existing wounds.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to maintain medical records that were accurate for 3 of 5 residents reviewed. The facility had conflicting information regarding Resident #1 and #3 intakes. The facility inaccurately documented the location of Resident #4's leg wounds. Facility census was thirty (30) residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #1 required extensive assistance with the assistance of 2 staff for transfers, dressing, bathing and toileting. The MDS assessed the resident with a Brief Interview for Metal Status (BIMS) score of 9 out of 15 (moderate cognitive deficit). The MDS indicated that the resident had [DIAGNOSES REDACTED]. An intake/output entry made on 9/15/20 at 1:00 PM revealed the resident ate 76%-100% of his breakfast meal, however the resident was in the hospital at that time. Nursing notes dated 9/14/20 at 12:10 p.m. revealed the resident admitted to the hospital. Nursing notes dated 9/17/20 revealed the resident readmitted from the hospital on [DATE] at 12:45 p.m. 2. An MDS dated [DATE] assessed Resident #3 with a BIMS score of 15 (no cognitive impairment) and [DIAGNOSES REDACTED]. According to meals eaten documentation on 9/28/20 at 10:55 AM and 1:40 PM the resident did not eat and at 6:43 PM for the evening meal it indicated that she was not available. The Fluids with Meals documentation on 9/28/20 at 10:58 AM and 1:22 PM indicated no fluid intake at the morning or lunch meal and the evening meal documented as not applicable at 9:26 p.m. A nursing daily skilled assessment dated [DATE] at 12:24 AM revealed the resident remained in bed the entire shift with good appetite and fluid intake. Nursing documentation dated 9/28/20 at 6:37 PM identified the resident's appetite as good and fluid intake good and resident alert. In an interview on 9/29 at 10:04 AM Interview with CNA Staff E worked on 9/28 she that when she emptied the urine bag that day, she noticed the urine to be darker than normal. She noticed that the resident hadn't eaten much, and that normally she would eat almost all of what is put in front of her. 3. A MDS dated [DATE] assessed Resident #4 with a BIMS score of 15 out of 15 (no cognitive impairment). The resident had [DIAGNOSES REDACTED]. According to the MDS, the resident was independent with transfers, eating, toileting and bed mobility. Observation on 9/28/20 at 10:30 AM revealed the resident in his room in a wheel chair and appeared sleeping with a protective boot on his right foot and his left leg absent from above the knee. A skin assessment dated [DATE], revealed the resident had a non-pressure skin tear on the top of his left lower leg. Follow up skin assessments dated 9/15, and 9/29 also referred to a skin tear on the left leg. A follow up skin assessment on 10/6/20 indicated that this skin tear was on his right leg.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation and interview the facility failed to maintain a sanitary environment to help prevent the development and transmission of pathogens. The facility reported a census of 30 residents. Findings include: 1. Observation revealed on 10/12/20 at 9:45 AM Staff F, CNA(certified nurse aide) changed out the biohazard bags from the trash cans. She pulled out the biohazard bag from one trash can and put it in with another one with ungloved hands and no gown. She then punched in the numbers on the locked breakroom and unlocked the shed where the biohazards are kept. She reentered the building and used hand sanitizer before going back into the floor. 2. Observation showed on 10/12/20 at 1:50 PM, Staff F sat at the nurse's station with her face shield off and mask under her chin. Two other staff members were within two feet of her at the time. 3. On 10/13/20 at 3:30 PM the Administrator acknowledged staff should wear gloves and gowns when taking out the biohazard bags and they must keep their face shields and masks on at all times.