| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165478 | A. Building<br>B. Wing | 11/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Court | 701 East Mapleleaf Drive<br>Mount Pleasant, IA 52641 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42842<br><br>Based on review of clinical records, resident interviews, Facility Staff interview and Clinical Staff interviews, the facility failed to provide adequate clothing for two resident of three residents reviewed (Resident #2 and #4) that leave the facility for appointments. The facility reported a census of 44 residents.<br><br>Findings include:<br><br>1. Review of Minimum Data Set (MDS) Assessment Tool dated 8/27/21 for Resident #2 revealed the resident's cognition intact based on a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS revealed diagnoses for Resident #2: hypertension, neurogenic bladder, quadriplegia, seizure disorder, anxiety, asthma, depression, COPD, pressure ulcer of sacral region, spondylosis, encephalopathy, muscle wasting and atrophy. The MDS revealed the resident had a pressure injury and the resident at risk for pressure injuries.<br><br>Review of the resident's Care Plan identified the resident with potential for impairment to skin integrity of the perineal area, buttock and bilateral upper extremity related to fragile skin and incontinence. The Care Plan revealed the resident with a pressure injury to the sacrum, right trochanter and left anterior upper thigh. The Care Plan also reported the resident with a diagnosis of anxiety and depression.<br><br>During an interview with the Clinical Wound and Vein Nurse Manager on 10/28/21 at 10:25 a.m., revealed the resident had come to the clinic before wearing a gown, no pants and her waist and legs covered with a blanket.<br><br>During an interview on 10/28/21 at 11:00 a.m., Resident #2 reported she had gone to the Wound Clinic in her hospital gown, she reported she is okay to wear a gown but clothing would be good too, she reported it doesn't feel good to wear just the gown to her appointments when its cold out.<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the MDS dated [DATE] for Resident #4 revealed diagnoses included anemia, atrial fibrillation (heart arrhythmia), hypertension (high blood pressure), neurogenic bladder, hip fracture, anxiety, depression, pressure ulcer of sacral region, intellectual disabilities and muscle weakness. The MDS reflected the resident's cognition as intact based on a BIMS score of l4 out of 15. The MDS revealed the resident required extensive assistance of two staff for transfers and dressing, and the resident utilized a wheelchair for mobility. The MDS reported the resident requires a suprapubic catheter, incontinent of stool and had a pressure ulcer.<br><br>Resident #4's Care Plan dated 10/18/2021 revealed the resident with a stage 4 pressure ulcer on her sacrum. The Care Plan also identified diagnoses of anxiety and depression and the resident with impaired cognitive function related to her intellectual disability. The Care Plan identified the resident required assistance of a Hoyer lift to get out of bed and the resident required assistance from staff and utilized a wheelchair.<br><br>Review of Clinical Records indicated the resident seen routinely by a Wound Clinic in a local city.<br><br>During an interview on 10/20/21 at 8:41 a.m., with the Clinical Staff Manager of the Wound Clinic Resident #4 goes to, revealed the resident came to the clinic on 10/14/21 with a shirt on, no pants and no incontinent pad. The Manager reported the resident had a sheet covering her lower extremities in the wheelchair upon arrival.<br><br>During an interview on 10/14/21 with the Director of Nursing (DON) reported Resident #4 sent to the Wound Clinic for an appointment and the resident given a maxi pad but no pants. The DON reported the resident sent to the clinic like this before, so the Wound Clinician could get easier access to the resident's wounds on her sacrum, and bilateral legs.<br><br>At the time of the survey, Resident #4, not available for an interview, resident admitted to the hospital on 10/15/21 and did not return during the survey.<br><br>CMS introduced the reasonable person concept in 1995 in Task 6 E of the State Operations Manual (SOM), Appendix P. The reasonable person concept described as follows: The absence of a reaction from a cognitively impaired resident who lacks the ability to understand and react to most stimuli, including those affected by the situation, and does not make the deficiency any less serious. In this case, the survey team should use the reasonable person concept to determine the severity level of psychosocial outcome for the person. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42842<br><br>Based on clinical record review, Facility Nursing Staff interviews, Wound Clinic Staff interviews, the facility failed to notify a Wound Specialist Physician of changes in resident's pressure ulcer for one of four residents observed (Resident #4). The facility reported a census of 44 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) dated [DATE] revealed Resident #4's diagnoses included anemia, atrial fibrillation (heart arrhythmia), hypertension (high blood pressure), neurogenic bladder, hip fracture, anxiety, depression, pressure ulcer of sacral region, intellectual disabilities and muscle weakness. The MDS reported the resident required extensive assistance of two staff for transfers and dressing, and the resident had a pressure ulcer.<br><br>Resident #4's Care Plan dated 10/18/2021 identified the resident at risk for potential pressure injury development related to history of injuries, limited sensory perception and limited mobility. The resident had a potential for impairment to skin integrity related to incontinence and leakage of urine around supra pubic catheter. The Care Plan revealed the resident had a Stage 4 pressure ulcer on her sacrum. Interventions expected of staff were to follow Facility Policies and Protocols for the prevention and treatment of skin breakdown to include:<br><br>a. Staff are to inform the resident's Guardian, caregivers of any new area breakdown.<br><br>b. Staff are to report any changes in skin status including appearance, color, temperature, and firmness.<br><br>c. Staff should also report wound healing and signs or symptoms of infection.<br><br>d. Staff should obtain and monitor any lab or diagnostic work as ordered and report any results to the Physician as indicated.<br><br>Review of the Weekly Wound Assessments revealed the resident had three pressure ulcers: 1. Sacrum, 2. Right lower extremity, and 3. Left lower extremity.<br><br>A Wound Assessment 9/27/21 reported the wound on the right lower extremity measured 2.2 centimeters (cm) by 1.4 cm with black eschar, necrotic tissue present and peri-wound tissue within normal limits.<br><br>On 10/4/21, the measurement of the right lower extremity measured 4.3 cm by 2.4 cm. The documentation identified the resident's peri-wound tissue red and inflammation preset, with the wound suspected of infection due to redness and a foul odor. The documentation reported the wound with slough tissue and necrotic tissue present. The progress of the wound documented as worsened.<br><br>A Wound Assessment documented on 10/11/21 reported the resident's wound measured at 8 cm by 4 cm and by 0.5 cm.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/20/21 at 11:10 a.m., the Facility Wound Nurse revealed she was out ill on 10/11/21. The Wound Nurse reported she completed rounds on Mondays with a Nurse Practitioner (NP) to assess wounds and change wound care orders as necessary. On the day the Wound Nurse out sick, the NP assessed wounds and documented them in the Electronic Medical Record (EMR).<br><br>During an interview on 10/21/21 at 9:40 a.m., the NP reported she rounded with the Facility Wound Nurse on 10/4/21, suspected infection for Resident #4's right lower leg wound, and prescribed an antibiotic for 10 days. The NP reported she rounded on 10/11/21, and the wound did not look infected and no bone showed. When asked about the wound size going from 4.3 cm by 2.4 cm to 8 cm by 4 cm by .5 cm, the NP reported not aware of changes in size of the wound. She reported she could not answer whether or not the facility should have called the Wound Care Clinic.<br><br>During an interview on 10/20/21 at 8:41 a.m., the Clinical Nurse Staff reported the facility never notified the Wound Clinic of the changes in the resident's wound.<br><br>During an interview on 10/21/21 at 8:21 a.m., the resident's Primary Physician reported she was not notified of the wound change but the Wound Clinic took over the resident's wound care. She reported she did receive a fax when the resident transferred to the local hospital.<br><br>Review of a policy entitled Notifying a Physician of a Change in a Resident's Condition dated 11/1/2018 revealed staff are to notify the resident's physician when there is a change in condition of the resident. |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42842<br><br>Based on clinical record review, staff and resident interviews, interview with Wound Clinicians, and review of facility policy, the facility failed to provide the necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for three of five residents reviewed with pressure injuries (Residents #2, #4, and #7). The facility failed to ensure transportation secured for all residents requiring wound clinic services. For Resident #4, review of the resident's Weekly Skin Sheets showed the resident's wound on 10/4/21 measured 4.3 centimeters (cm) x 2.4 cm, and no depth, with inflammation, redness, and possible infection. On 10/11/21, the wound measured 8.0 cm x 4.0 cm and a depth of 0.5 cm. The Wound Care Clinic reported not being informed of the change in status for the wound. The Wound Clinic observed the shin pressure sore and the bone visible within the wound. The resident transferred and admitted to the hospital on 10/15/21 and an above the knee amputation occurred on 10/22/21 due to osteomyelitis from the wound. This resulted in an Immediate Jeopardy, which the facility removed as of 10/28/21. The facility reported a census of 44 residents.<br><br>Findings include:<br><br>1. Review of the Minimum Data (MDS) Assessment Tool Resident #2 dated 8/27/21 documented the resident's cognition intact based on a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS identified diagnoses to include hypertension, neurogenic bladder, quadriplegia, chronic obstructive pulmonary disorder (COPD), pressure ulcer of sacral region, spondylosis, muscle wasting and atrophy. The MDS reported the resident at risk for pressure injuries, and showed the resident had two Stage 3 pressure injuries and one Stage 4 pressure injury at the time of the MDS. The MDS stated the resident received treatments to help with pressure injuries, which included pressure-reducing device for bed and chair, repositioning program, nutrition and hydration intervention in place, pressure injury care, application of non-surgical dressings and application of ointments or other medications.<br><br>The resident's Care Plan identified the resident with a self-care deficiency due to quadriplegia and required assistance with transfers, bed mobility and toileting. The Care Plan reported the resident is bedfast and had pressure injuries to the sacrum, left anterior upper thigh, and right trochanter. Staff directed to monitor dressings to ensure it the dressings are intact and adhering, report any changes in skin status and document treatments weekly to include measurement of each area including width, length, depth, type of tissue and exudate. Staff also to follow facility policy and protocols for the prevention and treatment of skin breakdown.<br><br>Review of the Pressure Injury Risk Assessment reported the resident's Braden Skin Score of 12 which is a high risk for a pressure injury. The assessment identified the resident of having very limited sensory perception, skin is often moist, the resident is often chairfast, and having very limited mobility.<br><br>Review of the resident's Wound Assessments revealed on 10/11/21 the wound on the left thigh measured 1. 5 centimeters (cm) by 1.2 cm by 0.5 cm., and then on 10/18/21 the wound measured 2.0 cm x 2.3. cm x 0.5 cm.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On the 10/11/21, the right thigh wound measured 0.5 cm by 1.5 cm by 0.2 cm, then on 10/18/21, the right thigh measured 2.0 cm by 3.0 cm by 2.5 cm.<br><br>An order for Resident #2 directed staff to apply Vashe wound therapy solution to the coccyx, left anterior upper leg and right upper leg, area every day and every evening shift.<br><br>The Treatment Administration Record (TAR) showed dates for treatment order of Vashe wound therapy solution not documented for left anterior upper leg on 10/5, 10/10, 10/19, 10/20, and 10/22. Further review of the TAR showed staff failed to document the Vashe treatment being applied for the right upper leg wound on 10/10, 10/11, 10/12, 10/19, 10/20 and 10/22.<br><br>A policy for Notifying a Physician of a Change in a Resident's Condition dated 11/1/2018, directed staff to notify the resident's physician when there is a change in condition of the resident.<br><br>A policy for Skin Management Guidelines dated 2/2016 directed the facility should consult with a Certified Wound Nurse or Surgeon and the Nursing Staff are to monitor the area closely during treatment to evaluate appropriateness of treatment regime.<br><br>During an interview on 10/27/21 at 11:25 a.m., Resident #2's Primary Nurse Practitioner (NP) reported the resident a patient of the Wound and Vein Clinic and missed a couple appointments. The Primary NP reported unsure when the dates were but she remembered she had to write a script for the resident to have an ambulance used as a transport vehicle for her to make it to her appointments so she didn't miss anymore.<br><br>During an interview on 10/28/29 at 12:25 p.m., the Clinical Wound and Vein Nurse Manager reported she remembered the resident did miss some of her appointments this past year but not documented in their charts for which dates Resident #2 missed.<br><br>2. The MDS dated [DATE] revealed Resident #4's diagnoses included: anemia, atrial fibrillation (heart arrhythmia), hypertension (high blood pressure), neurogenic bladder, hip fracture, anxiety, pressure ulcer of sacral region, intellectual disabilities and muscle weakness. The MDS reported the resident required extensive assistance of two staff for transfers and dressing, with the resident at risk for developing pressure injuries, and also identified the resident with a current pressure ulcer<br><br>Resident #4's Care Plan dated 10/18/2021 identified the resident at risk for potential pressure injury development related to history of injuries, limited sensory perception and limited mobility. The resident had a potential for impairment to skin integrity related to incontinence and leakage of urine around supra pubic catheter. The Care Plan revealed the resident had a Stage 4 pressure ulcer on her sacrum. Interventions expected of staff are to follow facility policies and protocols for the prevention and treatment of skin breakdown as follows:<br><br>a. Staff are to inform the resident's guardian, caregivers of any new area breakdown.<br><br>b. Staff are to report any changes in skin status including appearance, color, temperature, and firmness.<br><br>c. Staff should also report wound healing and signs or symptoms of infection.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | d. Staff should obtain and monitor any lab or diagnostic work as ordered and report any results to the physician as indicated.<br><br>Further review of the resident's Care Plan reported the resident required assistance with two staff members for bed mobility and toileting, and required assistance of a Hoyer lift and two staff for transfers.<br><br>Review of the resident's Pressure Injury Risk Assessment documented the resident had a Braden skin score of 14 which identified the resident as a moderate risk for pressure injuries. The assessment showed the resident as having very limited mobility, inadequate nutrition and skin occasionally moist.<br><br>Review of the Weekly Wound Assessments revealed the resident had three pressure ulcers: 1. Sacrum, 2. Right lower extremity, and 3. Left lower extremity.<br><br>A Wound Assessment on 9/27/21 reported the wound on the right lower extremity measured 2.2 centimeters (cm) by 1.4 cm with black eschar, necrotic tissue present and peri-wound tissue within normal limits.<br><br>On 10/4/21, the measurement of the right lower extremity measured 4.3 cm by 2.4 cm. The documentation showed the resident peri-wound tissue red and inflammation present. The document showed the wound suspected of infection due to redness and a foul odor, and also documented the wound had slough tissue and necrotic tissue present. The progress of the wound documented as worsened.<br><br>A Wound Assessment documented on 10/11/21 reported the resident's wound measured at 8.0 cm by 4.0 cm and by 0.5 cm.<br><br>Review of the Nurse Practitioner (NP) Progress Note dated 10/11/21 at 11:02 a.m., showed an assessment of the resident's skin and wounds including the wound on the right lateral aspect of the leg, which measured 8.0 cm x 4.0 cm x 0.5 cm. The NP documented large amount of foul black drainage on the old dressing and minimal erythema surrounding the wound bed.<br><br>Review of the Progress Notes revealed on 10/1/21 at 2:39 p.m., the facility Social Worker (SW) attempted to call an insurance group to schedule transport for the resident's upcoming appointment but unable to do so because the insurance had the wrong address on file. The SW called the resident's Guardian to update the address so the trip with the transport service could be scheduled. On 10/1/21 at 3:21 p.m., the address updated for the insurance company and the transport service to call with transport information.<br><br>A Progress Note dated 10/8/21 at 1:41 p.m., revealed the transport service to call next week and give a trip number. The writer stated in the note if the transport service does not call by Tuesday (10/12/21) the transport company would be called.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of documentation from the Wound and Vein Center revealed the resident missed two appointments on 9/23/21 and 10/7/21. The resident's last appointment was on 9/9/21. The documentation showed when the resident came to the clinic on 10/14/21, she had multiple ulcers which are not reflected in the facility's Weekly Skin Assessments in the Electronic Medical Record (EMR). The documentation showed Resident #4 had several ulcers on her left upper back, left lower back, left medial knee, right medial knee, open sacral ulcer, right 2nd toe and left flank. The documentation identified the resident's right medial ulcer progressed to a Stage 4 ulcer down to the tibial bone and reported orders for the facility to send the resident to the emergency room (ER) to have her wounds further evaluated.<br><br>Further documentation review showed a brief interview between Resident #4 and the Wound Clinician, which showed the resident taking an antibiotic, is a smoker and spends more of her days in bed staring at the wall.<br><br>Review of the local hospital's documentation noted the resident admitted to local area hospital on 10/15/21 at 11:30 a.m The documentation showed the resident admitted with multiple chronic ulcers and a Stage 4 ulcer with visible bone on the right shin with purulent discharge. The documentation showed the resident required two different intravenous (IV) antibiotics and had an elevated white blood count (WBC) which indicated the resident had an infection. The clinical impression indicated suspicion of right lower leg cellulitis, possible osteomyelitis with a Stage 4 pressure ulcer with exposed bone. A wound culture obtained showed the wound bed infected with enterococcus. An x-ray obtained on 10/15/21 for right lower leg injury showed suspicious for chronic osteomyelitis. A Progress Note documented the resident on a waiting list to be transferred to a higher-level care hospital due to the likely need of surgical consultation and long-term IV antibiotics. Review of the Surgical Consult Notes for Resident #4 reported the surgeon wanted to perform an above-the-knee amputation, on an urgent basis, to give the resident the best chance for survival. The documentation showed a Progress Note with plans for the resident to go into surgery for amputation on 10/19/21.<br><br>During an interview on 10/20/21 at 11:10 a.m., the facility Wound Nurse reported she was out ill on 10/11/21. The Wound Nurse reported she rounds on Mondays with a rounding Wound Nurse Practitioner (NP) to assess wounds and change wound care orders as necessary. On the day the Wound Nurse out sick, the NP assessed wounds and documented them in the electronic medical record.<br><br>During an interview on 10/20/21 at 8:41 a.m., the Clinical Wound and Vein Nurse Manager reported the facility never notified them of the changes in the resident's wound and the resident missed two of her appointments on 9/23/21 and 10/7/21. She reported the Wound Clinic makes sure to call the facility the day before and notify staff at the facility of the upcoming appointment. The Manager reported the resident didn't have an appointment on 10/14/21 but showed up and so they worked the resident in since she had missed two previous appointments. An additional interview on 10/28/29 at 12:25 p.m., the Clinical Wound and Vein Nurse Manager reported she felt the facility responsible because the resident missed her scheduled appointments to the Wound Clinic, and felt it contributed to the resident's wounds worsening.<br><br>An interview on 10/20/21 at 3:30 p.m., the Social Worker stated she had issues with insurance when she called to schedule an appointment for transport. She reported the insurance group would not schedule transport until the issue with the address fixed. She reported the insurance still had the old address on file and worked with the insurance group for about two weeks trying to get the address changed. She reported any of the wound care clinic appointments, which were missed, were rescheduled.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | An interview on 10/21/21 at 9:40 a.m., the Wound Rounding NP reported she rounded with the facility Wound Nurse on 10/4/21, and suspected infection for Resident #4's right lower leg wound, and prescribed an antibiotic for 10 days. The NP reported she rounded on 10/11/21, and the wound did not look infected and no bone showing. When asked about the wound size going from 4.3 cm by 2.4 cm on 10/4/21 to 8.0 cm by 4. 0 cm by .5 cm on 10/11/21, the NP reported not aware of change in size of the wound. She reported she could not answer whether or not the facility should have called the Wound Care and Vein Center Clinic.<br><br>Review of Skin Management Guidelines dated 2/2016 instructed on staging classification for ulcers. The Guideline reveals characteristics of a Stage 4 ulcer show full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough, and/or eschar may be visible.<br><br>3. Resident #7's MDS dated [DATE] showed the resident's cognition intact with a BIMS score of 15 out of 15. The resident diagnoses included; anemia, hypertension, hyperlipidemia, cerebrovascular accident (stroke), muscle weakness, difficulty with walking, and muscle wasting. Review of the MDS identified the resident required extensive assistance of two staff members for toileting and utilized a walker and a wheelchair for mobility devices. Further review revealed the resident always incontinent of urine and stool. The MDS documented the resident at risk for developing pressure injuries and the resident with two venous and arterial ulcers present and had skin injury treatments including pressure-reducing device for chair, nutrition and hydration intervention, application of nonsurgical dressing, ointments or medications and applications of dressings to his feet.<br><br>Review of the resident's Care Plan identified the resident at risk fro potential pressure injury, impaired skin integrity and venous wound development related to edema, incontinence, limited mobility, and history of pressure injury. Staff directed to follow facility policies and protocols for the prevention and treatment of skin breakdown. The Care Plan documented the resident with impairment of skin integrity due to maceration of the buttocks from chronic bowel incontinence.<br><br>Review of the resident's Pressure Injury Risk Assessment revealed the resident's Braden Skin Score as a 14 which means the resident is a moderate risk for skin injury. The assessment identified the resident as having skin often moist, the resident as chairfast, and her mobility as very limited.<br><br>Review of the TAR for resident #7 documented an order for staff to cleanse area, apply collagen particles and Dermaseptine and then cover the right buttock with a silicone dressing daily. Further review of the TAR revealed the treatment not documented for 10/5, 10/9, 10/10, 10/11, 10/16 and 10/17.<br><br>During an observation on 10/28/21 at 9:00 a.m., noted the facility Wound Care Nurse administering treatments to the wounds, the resident lifted via a sit-to-stand lift, his pants pulled down and the wound cleaned. At the time of the observation, currently no dressing to the resident's right bottom noted and the area open to air. The staff member cleaned the resident's bottom, applied the topical ointments, and then placed the dressing to the resident's bottom. The resident began to have loose stools.<br><br>An interview on 10/27/21 at 11:25 a.m., Resident #7's primary NP reported she came in to assess her resident's and found Resident #7's bottom macerated and no wound dressing on. She reported she knows there is an order for a wound dressing to his bottom but the resident did not have it on.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165478 | A. Building<br>B. Wing | 11/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Court | 701 East Mapleleaf Drive<br>Mount Pleasant, IA 52641 |

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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 10/28/21 at 10:15 a.m., Staff A, Certified Nurse's Aide (CNA) reported when a wound dressing comes off during cares with Resident #7, staff are to inform the facility Wound Care Nurse so she may replace it.<br><br>During an interview on 10/28/21 at 10:22 a.m., Resident #7 reported staff are good about getting him cleaned up. He reported he has bowel issues because he does not have a portion of his colon. The resident reported when he has loose stools, the dressing will come off but then it is not always replaced.<br><br>The State Agency informed the facility of the Immediate Jeopardy on October 28, 2021 at 3:30 p.m.<br><br>The Facility removed the Immediate Jeopardy on October 28, 2021 by implementing the following actions:<br><br>a. The Director of Nursing (DON) and Wound Care Certified Licensed Practical Nurse (LPN) completed a 100% Skin Assessment of all residents at the facility. All treating physicians updated on current assessments of wounds including measurements.<br><br>b. The DON and Wound Care Certified Nurse received education on changes in wounds and expectations via a Zoom meeting by a Regional Nurse consultant.<br><br>c. All professional staff will receive education on wound decline identification, Skin Management Guidelines, Practice Guidelines and Derma Rite Wound Care Quick Reference Formulary and requirements for immediate notification of the Primary Care Physician and the Wound Care Center, if the resident is being followed by a Center, and no professional staff will work additional shifts prior to education.<br><br>d. [NAME] Wound Physician will begin weekly observations either via Telehealth or In Person Visits beginning the week of November 1, 2021 for pressure injuries<br><br>e. Weekly skin assessments will be reviewed the next business day by the Quality Assurance Performance Improvement (QAPI) Team to ensure that notifications and changes were documented appropriately.<br><br>f. Audits to review physician notifications/updates will occur 5 times weekly.<br><br>The scope lowered from K to E at the time of the survey after ensuring the facility implemented education and updated their policy and procedure. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42842<br><br>Based on clinical record review, observations, staff and resident interviews, the facility failed to provide clean linens for one of six residents observed (#6). The facility reported a census of 44 residents.<br><br>Findings Include:<br><br>Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #6's cognition intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15. Review of the MDS revealed the resident required assistance of one staff member for toileting.<br><br>Review of the Care Plan showed the resident with diagnoses of history of duodenal ulcer, Diabetes Mellitus, Myasthenia Gravis, and hypertension. The Care Plan revealed the resident is incontinent of urine.<br><br>An observation on 10/19/21 at 3:30 p.m., revealed a smell of bowel movement (BM)/stool very apparent in Resident #6's room, noting possible stool stains on Resident #6's linens and on a blue chuck pad in the resident's chair.<br><br>An observation on 10/20/21 at 12:06 p.m., revealed the resident with soiled linens and a soiled blue chuck pad on the chair in the resident's room.<br><br>An observation 10/20/21 at 2:08 p.m., revealed Resident #6's bed remained with sheets stained with stool and the chair still with a blue chuck pad stained with stool.<br><br>An observation on 10/21/21 at 8:34 a.m., revealed the bed sheets appear to be the same soiled with stool, although a new blue chuck pad on the bed, and the blue chuck pad in the chair appears the same as seen on 10/20/21 with stool stains.<br><br>During an interview on 10/21/21 at 1:30 p.m., the Administrator stated the facility does not have a policy regarding sheet changes but expectations for staff are to change sheets on shower/bath days or as needed.<br><br>During an interview on 10/26/21 at 10:20 a.m., Resident #6 reported the bed soiled for the last week for a few days but did not mind his bedding soiled as long as the bed not completely soaked. |