STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165204	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keosauqua Health Care Center	819 Country Lane Road Keosauqua, IA 52565

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	Ensure services provided by the nursing facility meet professional standards of quality. 47336 Based on clinical record review, policy review, provider and staff interviews the facility failed to implement a physician order to change a type of wound dressing for 1 of 3 residents (Resident #6) with a wounds. The facility reported a census of 57 residents. Finding include: The Minimum Data Set (MDS) assessment, dated 9/12/24, revealed Resident #6 scored a 15 out of 15 on the Brief Interview for Mental Status, indicating intact cognition. The MDS revealed the resident required partial/moderate assistance with rolling from left to right; sit to standing; and upper body dressing. The MDS identified the resident dependent for chair/bed to chair transfers. The MDS list of diagnoses included necrotizing fasciitis (bacterial infection that destroys tissue under the skin), diabetes mellitus, and wound infection. The MDS documented the resident had two Stage III pressure ulcers present on admission, along with surgical wounds. The Nursing Note dated 9/6/24 at 2:52 PM revealed resident arrived at facility via hospital transport accompanied by transport driver. Resident is a spina bifida (malformation of spinal cord) and has been whole life. Resident lives alone and cares for self, resident has 2 grown children, and a 14 lb (pound) cat. Resident has an ileostomy (opening in abdominal wall to allow collection of waste outside of the body) on her right abdomen and a colostomy (another name for opening in abdominal wall) on her right abdomen. Resident is independent with providing her own ostomy (opening in abdominal wall) cares and prefers to provide her own ostomy cares. Resident recently had necrotizing fasciitis and has a right buttock wound up through her right vaginal area. Resident states she doesn't get dressing change until after she receives a pain pill because the dressing is so painful. Resident states she has a motorized wheelchair at home and that is her mobility. Resident has mepilexes (a type of absorbent foam dressings) on each heel the right is for prevention and the left is for a wound. Resident oriented to her room and routine. The Care Plan, Date Initiated: 9/11/24, Revision on: 9/20/24 included a Focus area to address [Name redacted] has an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) necrotizing fascilitis. Interventions included, in part; [Name redacted] is a one assist with repositioning in bed. Resident able to help with repositioning, [name redacted] utilizes an AIR mattress d/t (do to) wounds on a bariatric (heavy duty bed) bed. Interventions Date Initiated: 9/20/24. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan, Date Initiated: 9/20/24, included a Focus area to address [Name redacted] has 2 pressure ulcers r/t immobility. Dx (diagnosis) of necrotizing fasciitis. Interventions included, in part; Assess/record/observe wound healing (FREQ) (frequently). Measure length, width, and depth where possible. Assess and document state of wound perimeter, wound bed healing progress. Report improvements and declines to the MD (medical doctor). Intervention Date Initiated: 9/20/24. A review of Physician Orders revealed: a. Ordered on 10/6/24- Vashe wound sol therapy Left heel stage 3 ulcer. Cleanse with vashe and pat dry. Apply prisma or equivalent to wound bed only and cover with bordered foam silicone dressing daily. Encourage side to side positioning and heal suspension. b. Cleanse buttock open area with Vasche daily. Apply Puracol or equivalent directly onto wound bed, cover with foam adhesive bandages. One time a day for wound care. Encourage side to side positioning and heel suspension. Ordered 10/10/24. c. Hydrocodone/acetaminophen 7.5/325 mg (milligrams)- 1 tab every 4 hours as needed for moderate pain. Ordered 9/14/2024. The provider Clinic Note, dated 11/1/24, for a Nursing Home Visit revealed: a. Primary diagnosis: Pressure ulcer of right buttock, stage 3 b. Chief complaint: follow-up c. History of Present Illness: Resident #6 is being seen at [facility name redacted] for follow up on her wounds: left heel pressure ulcer, vulva and buttocks from previous surgical debridement due to necrotizing fasciitis. She previously had pressure areas to sacrum and buttocks as she is wheelchair bound due to spina bifida. Had extensive debridement at [hospital name redacted] in [city and state redacted]. Since being admitted to [facility redacted] to [facility name redacted] she has had been receiving daily dressing changes. Had previously discussed having wound consult and treatment with wound clinic at [hospital name redacted] and she declined. Today she denies any new pain. States that the left heel rarely has pain given her spina bifida. Reports that perineum and buttocks are only painful with dressing changes and that levels vary depending. Nurse states that Resident #6 continues to be resistant to lying side to side and does not get out of bed. States that she has not had any follow up with surgeon since admission in August. Nurse feels as thought the heel is stable, but buttocks wounds are worsening. d. Assessment and Plan 1. Current medications and orders reviewed-advised of orders that were duplicated, completed or no longer applicable 2. [Facility name redacted] chart reviewed including notes and assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Epic records since previous visit reviewed including consultations, labs and imaging if applicable . 4. New orders given today: wound consult at [hospital name redacted] (was told after visit that she would like to be seen), wound culture and will start Doxycycline while waiting for results. 5. Follow up per nursing home guidelines and as needed. The untitled facility form, with facility name, address and phone number, dated 11/1/24, revealed, in part; a. Wound location: buttocks 1. Etiology: Pressure Stage III 2. Cleanser: Vashe 3. Primary Dressing: Calcium Alginate AG- cut to size of wound 4. Secondary dressing: non-adherent then ABDs 5. Secure with: Paper and silicone tape 6. Frequency: daily and PRN (as needed) b. Wound location: right heel prevention 1. Primary dressing: hydrocolloid 2. Frequency: change Q (every) 3 d (days) and PRN Provider Signature and Date: [Name redacted], 11/1/24. The second page of the untitled form, labeled Provider Order Form, dated 11/1/24, revealed; Orders: 1. Culture of wound. Take to [hospital name redacted]. Completed during visit. 2. Start doxycycline 100 mg PO BID (twice daily) x 10 days. DX (diagnosis): wound infection. Provider Order Form signed on 11/1/24 by provider [name redacted]. The Provider Order form did not have documentation of facility review. A review of the clinical record did not reveal documentation of the 11/1/24 wound dressing orders for the heel and buttocks orders or implementation of the orders. A Nursing Note, dated 11/2/24 at 7:27 PM, revealed resident was initiated on ATB (antibiotic) [doxycycline] 100 mg i po (oral) bid x 10 days for dx of wound infection. first dose was pulled from cubex (brand name of medication storage/dispensing equipment). temp 97.2 tymp. (tympanic - temperature taken via ear canal) notice was received from pharmacy statingATTN: nursing staff. [name redacted] Pharmacy staff is clarifying (doxycycline) med not covered by insurance. will await a response. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Note, dated 11/6/24 at 3:10 PM, revealed Call received from [name redacted for local hospital] regarding resident's return from wound clinic appointment. [Provider's name redacted] has ordered an IV (intravenous) antibiotic for resident to be treated with every 12 hours. Informed [local hospital name redacted] team that [facility name redacted] can not accommodate every 12 hour IV antibiotics and that we do not feel comfortable accepting her back with that order. [local hospital name redacted] asked if resident would be accepted back following completion of IV antibiotic therapy, and they were informed that we will accept resident back at that time. [name redacted] stated she would call back when she had more information. During an interview on 11/12/24 at 4:00 PM, Staff B (Registered Nurse) after queried on Resident #6 orders stated she reviewed the orders under the documents tab in the EMR (electronic medical record) and then reviewed the resident's chart. Staff B stated she didn't see the new dressing orders. Staff B asked when wound dressing orders get processed and she stated usually right away, they sent it to pharmacy and they put them in and discontinued the old order. Staff B stated she was not sure what happened and she couldn't find anything for the dressing change order on 11/1. Staff B stated she didn't see a progress note for the wound dressing orders. During an interview on 11/13/24 at 9:12 AM, Staff A, Advanced Registered Nurse Practitioner (ARNP) after queried on the resident's new orders for dressing changes on 11/1/24 stated she would of liked to been notified if the supplies not available to change the dressing and she didn't see where anyone notified her. Staff A stated she expected new orders for dressing changes to be implemented at the next scheduled dressing change. Staff A stated she was not aware the new dressing changes didn't get started. During an interview on 11/13/24 at 11:19 AM, Staff C, RN after queried about Resident #6 wounds stated she saw Resident #6 with Staff A, ARNP on rounds on 11/1/24 and said Staff A went through everything with her and Staff C told Staff A she was unclear on the wound dressing orders. Staff C stated Staff A stated she would write down the orders and Staff C shift was over before the orders received. Staff C stated the night or weekend nurse would of taken care of it. During an interview on 11/13/24 at 1:47 PM, the Administrator after queried about how orders being processed worked explained they received the orders from the providers when the residents seen and they gave the orders directly to the nurse and if the resident seen at the clinic, they came back with orders and the orders given to the nurse. The Administrator stated the nurse manually put the orders into the computer. The Administrator informed of the new dressing change orders for Resident #6 and she stated she expected the orders go in when they are received and she would do re-education on the processing of orders. During an interview on 11/13/24 at 3:52 PM, the DON (Director of Nursing) after queried on Resident #6 new wound dressing change orders stated she expected the staff to be doing the new dressing changes as ordered and they needed to make sure the orders placed in the computer when they received it. A facility policy, dated November 2014, titled Medication Orders, Purpose statement declared The purpose of this procedure is to establish uniform guildelines in the receiving and recording of medication orders. The Recording Orders section #6. Treatment Orders - When recording treatment orders, specify the treatment, frequency, and duration of the treatment.