STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165241	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grundy Care Center	102 East J Avenue Grundy Center, IA 50638

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 48003 Based on observations, interviews, and record review, the facility failed to accurately document pressure ulcers for 1 of 3 residents reviewed (Resident #1). During the record review of Resident #1's record, the assessments revealed inconsistent documentation related to their wound on their right buttock. As the wound declined, the facility failed to update the stages of the pressure ulcer with worsening changes. The facility reported a census of 27 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Regardless of the staging system or wound definitions used by the facility, the facility is responsible for completing the MDS utilizing the staging guidelines found in the RAI (Resident Assessment Instrument) Manual. Stage 1 Pressure Injury: Non blanchable erythema of intact skin Intact skin with a localized area of non blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer: Partial thickness skin loss with exposed dermis Partial thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full thickness skin loss Full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Stage 4 Pressure Ulcer: Full thickness skin and tissue loss 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 on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Unstageable Pressure Ulcer: Obscured full thickness skin and tissue loss Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Other staging considerations include: o Deep Tissue Pressure Injury (DTPI): Persistent non blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. Resident #1's Minimum Data Set (MDS) assessment dated [DATE], reflected they had no pressure ulcers during the assessment lookback period. The History And Physical dated 8/5/24 documented Resident #1 saw the wound clinic for a furuncle (also known as a boil, is a painful, pus filled bump on the skin that results from a bacterial infection of the hair follicle). The Weekly Skin Assessment - V5 dated 7/24/24 reflected Resident #1 had an abscess to his right buttock that measured 1.8-centimeter (cm) length by (x) 0.6 cm width x 0 depth, no stage. The Weekly Skin Assessment - V5 dated 7/30/24 indicated Resident #1 had an abscess to his right buttock that measured 2.1 cm length x 0.6 cm width x 0 depth, no stage. The Weekly Skin Assessment - V5 dated 8/6/24 indicated Resident #1 had a abscess to his right buttock that measured 2.4 cm length x 1.8 cm width x 0 depth, stage I. In addition, he had a skin tear to his buttock that measured 1.7 cm length x 0.4 cm width x 0.1 cm depth, stage II. The buttock had thin, watery, clear drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Weekly Skin Assessment - V5 dated 8/13/24 indicated Resident #1 had an abscess to his right buttock that measured 3.8 cm length x 3.5 cm width x 0 depth, stage I. In addition, he had a skin tear to his buttock that measured 1 cm length x 0.4 cm width x 0.1 cm depth, stage II. The right buttock had thin, watery, pale, red/pink drainage. The Weekly Skin Assessment - V5 dated 8/20/24 indicated Resident #1 had three abscesses to his right buttock. a. Type: Redness - Abscess that measured 10.5 cm length x 18 cm width x 0 depth, Not Applicable (N/A) stage. b. Type: Blackened - Abscess that measured 6.8 cm length x 7.7 cm width x 0 depth, N/A stage. c. Type: Abscess that measured 1.1 cm length x 1.1 cm length x 0.1 cm, stage II. i. The 2 abscesses on the right buttock had a scant amount of purulent drainage (a thick, milky consistency, with a green or yellow appearance indicating an infection) with hardness noted to the surrounding skin/wound edges. During an interview on 8/26/24 at 2:25 PM Staff A, Registered Nurse, reported it is different each week who did the skin assessments, as it is the nurses on the floor who complete them each week. When asked if they had any training on skin assessments she reported the facility didn't have special training. She reported each nurse may measure and document things differently. She reported Resident #1 had a boil that turned into an open pressure area. During an interview on 8/26/24 at 3:07 PM, the Advanced Registered Nurse Practitioner (ARNP) reported it changed very quickly. She voiced she didn't like the inconsistency in documentation for the wounds because it made it hard to determine what it looked like until she saw it on rounds. She saw Resident #1 the day the facility sent him to the hospital. That is why they ordered labs and did the creatinine level, he was sent out. He had black necrotic tissue over a pressure area. During an interview on 8/26/24 at 3:25 PM the Nurse Consultant reported the facility had inconsistency in their skin assessments. She reported that she didn't know why they staged Resident #1's skin tear if it wasn't a pressure ulcer. She added the facility didn't have consistent staging with each assessment. The Skin Care and Wound Management policy dated June 2015 defined a pressure ulcer as a localized injury to skin and/ or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Monitor for consistent implementation of interventions and effectiveness of the interventions