STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165278	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Center West	1050 4th Avenue SE Cedar Rapids, IA 52403

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126 20331 Based on clinical record review, facility policy review, and staff interviews, the facility failed to notify 1 of 3 resident's family/guardian in a timely manner when the resident had a change in condition (Resident #2). The facility reported a census of 85 residents. Findings include: The MDS (Minimum Data Set) an assessment tool dated 3/7/2024 revealed Resident #2 had moderately impaired cognitive abilities, dependent on staff to transfer from one surface to another, failed to ambulate, had a history of falls prior to admission, had a skin tear that required a dressing, and no pressure ulcers. The resident admitted to the facility on [DATE]. The Resident's Census Report revealed the resident had a room change on 3/11/2024. The resident's admission record documented the resident had a responsible party, guardian, conservator, and emergency contact #1 person listed, not a family member. In the Progress Notes, an admission assessment dated [DATE] identified the resident had a skin tear to the right upper arm and scattered faint bruises to the left arm. The note failed to indicate staff notified the resident's guardian of the skin issues. A Progress Note dated 4/4/2024 revealed the resident's family visited and noted bruising to the resident's bilateral upper extremities. Staff noted faded purple bruise to the left lower forearm that measured 3 cm (centimeters) by 2.5 cm, faded purple bruise to the left upper forearm that measured 2 cm by 2 cm., and yellow to faded red scattered bruising to the right lower forearm. Staff A, LPN (Licensed Practical Nurse) initiated skin assessment sheets and indicated family aware from being at the facility. Staff A failed to document guardian notification. No Progress Note documented the resident had a room change on 3/11/2024. Staff failed to document they notified the resident's guardian of the room change. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/2024 at 1:45 P.M., Staff A, LPN indicated family identified Resident #2's bruises during their visit on 4/4/2024; therefore they knew about the issue. Staff A initiated the skin assessment sheets. The bruises looked like they may have been present for awhile, some were faded. Staff A failed to notify the guardian. On 5/6/2024 at 1:00 P.M., Staff B, DON (Director of Nursing) revealed staff should have initiated the skin assessment sheets upon admission. The nurse performing the admission assessment should have notified the resident's family or guardian of any identified concerns. Staff B had the responsibility of notifying the responsible party when a resident had a room change. The clinical record failed to document Staff B made the guardian aware when Resident #2 changed rooms. The facility policy regarding Physician Notification effective 10/10/2019 included: To inform a physician of a resident's change in condition. PROCEDURE: 1.) Physicians will be notified promptly of the following: A. Any accident or unusual incident. B. Any accident or incident which results in injury which may require physician intervention. C. A significant change in resident condition which is life threatening. D. A significant change in resident condition which has potential for clinical complication (i.e. urinary tract infections, open skin, etc.) E. A change in condition which requires a significant alteration in treatment. F. Death of a resident. G. Discharge or transfer of a resident. EFFECTIVE: 10/10/2019 REVISED: The resident's representative shall be notified of any accident, injury, or adverse change in a resident's condition requiring physician notification. PROCEDURE: Resident representatives shall be notified of the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Any accident or unusual incident, regardless of injury. A significant change in a resident's condition. o Death o Discharge or transfer to another healthcare facility or home. - Any change in condition which may be life-threatening should be immediately called. Same day notification may be utilized for condition changes that are not life- threatening. Next day notification may be utilized for condition changes that are not life- threatening and occur during sleeping hours. Attempts to notify the resident representative shall be documented in the clinical record. A minimum of 3 attempts must be made. Residents who are designated as their own responsible party may exercise their right to refuse family notification. The facility Room Change policy dated 5/2/2022 included: POLICY: The resident or resident's representative will be notified prior to a change in room or roommate. PROCEDURE: Prior to the change: The resident or resident's representative will be notified prior to a change in room or roommate. A change in room assignment will be documented in Point Click Care through a census entry.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20331 Based on clinical record review, observation, facility policy review, staff and resident interviews, the facility failed to provide appropriate skin assessment and interventions for 2 of 6 residents reviewed (Residents #1 & #2). The facility reported a census of 85 residents. Findings include: 1. The MDS (Minimum Data Set) an assessment tool dated 3/7/2024 revealed Resident #2 had moderately impaired cognitive abilities, dependent on staff to transfer from one surface to another, failed to ambulate, had a history of falls prior to admission, a skin tear that required a dressing, and no pressure ulcers. The resident admitted to the facility on [DATE]. In the Progress Notes, an admission assessment dated [DATE] identified the resident had a skin tear to the right upper arm and scattered faint bruises to the left arm. The note failed to indicate staff notified the resident's guardian of the skin issues. A Progress Note dated 3/11/2024 revealed the skin tear healed and staff made the resident's guardian aware. A Progress Note dated 4/4/2024 revealed the resident's family visited and noted bruising to the resident's bilateral upper extremities. Staff noted faded purple bruise to the left lower forearm that measured 3 cm (centimeters) by 2.5 cm, faded purple bruise to the left upper forearm that measured 2 cm by 2 cm., and yellow to faded red scattered bruising to the right lower forearm. Staff A, LPN (Licensed Practical Nurse) initiated skin assessment sheets and indicated family aware from being at the facility. Staff A failed to document he notified the guardian. Observation on 5/6/2024 at approximately 11:40 AM revealed the resident in bed on her back with a body pillow placed on her right side. The resident's right upper arm had a gauze dressing with tape that appeared dark red in color. The resident's right upper arm had a small amount of dried blood present. The resident's left arm had scattered bruises and dark/red discoloration. Staff C, CNA (Certified Nurse Aide) indicated she needed to report the right upper arm concern to the nurse. A Progress Note dated 5/6/2024 at 8:36 PM, revealed physician orders for the wound treatment. On 5/6/2024 at 1:45 PM, Staff A, LPN indicated family identified Resident #2's bruises during their visit, therefore they knew about the issue. Staff A initiated the skin assessment sheets. The bruises looked like they may have been present for awhile, some were faded. Staff A failed to notify the guardian. On 5/6/2024 at 1:00 PM, Staff B, DON (Director of Nursing) revealed staff should have initiated the skin assessment sheets upon admission. The nurse performing the admission assessment should have notified the resident's family or guardian of any identified concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident had intact cognitive status. The resident experienced a hospitalization from ,d+[DATE]-[DATE] and returned with a BIMS score of 3, which indicated severely impaired cognitive ability. The MDS revealed the resident moved about the facility via his wheelchair independently and had independence with personal cares. The MDS revealed the resident had diagnoses which included Dementia, peripheral vascular disease, chronic foot ulcers, heart disease, and chronic leg wounds with cellulitis. Review of the Care Plan dated 8/21/2023 indicated the resident had a risk for skin breakdown due to physical deconditioning, peripheral vascular disease, dementia, and neuropathy. The Care Plan directed the staff to document weekly; measurements, drainage, and any other notable changes and to contact the resident's physician with changes noted. Review of nursing Progress Notes from 3/15/24 - 5/1/24 failed to include documentation of wound assessments with included measurements and the condition of the venous ulcers. Observations on 5/6/24 at 1:00 PM revealed Staff E-LPN remove the residents bilateral lower leg dressings which enabled Staff D-LPN/Facility Skin Nurse as of 5/6/24 to measure the resident's leg wounds. Staff D measured three areas of impaired skin: -Wound A located on the resident's left lateral malleous measured 3 cm x 5 cm with 50% granulation and 50% slough. -Wound B located on the right lower lateral shin area which measured 17.5 cm x 7 cm x .3 cm in depth with 75 % slough. Wound B appeared to be actively dripping serous fluid. -Wound C located on the right dorsal foot measured 20 cm x 7.5 cm x 0.1 cm in depth. The resident's Primary Care Physician present during the dressing change and stated all of the wounds are considered venous ulcers and will most likely not be healed due to severe venous insufficiency. Review of the Wound/Skin healing records for Wound A-revealed the nursing staff completed a skin assessment on this wound on 2/8/24, 2/28/24, 3/13/24, and 5/5/24. Review of the Wound/Skin healing record for Wound B revealed 2 wounds on the right dorsal foot and the right anterior leg conjoined into the current Wound B. Review of the skin sheets revealed the staff completed skin assessments on these wounds on 1/17/24, 2/8/24, 3/13/24, and 5/5/24. Review of the Wound/Skin healing records for Wound C revealed the resident had a wound on his right medial ankle, first discovered on 12/13/23. The staff assessed the wound on 12/13/23, 2/28/24, and 5/5/24. During an interview with Staff B/RN/Director of Nurses on 5/6/24 at 11:30 AM, Staff B stated she did not have any additional skin sheets for Resident #1, stating the staff failed to complete weekly skin assessments on the resident's wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff B/RN/Director of Nurses on 5/8/24 at 10:00 AM, Staff B stated the nurses are required to complete weekly assessments on every resident with a skin issue. The nurse is expected to report to the resident's Primary Care Provider changes noted to the wound, to request changes in the treatment regime if needed. Staff B stated prior to 5/6/24 they did not have a skin nurse but has since assigned Staff D/LPN to this task, prior to Staff D's assignment each charge nurse for the resident on the day assessments were due was responsible to complete the wound assessment. During an interview with Staff E/LPN on 5/6/24 at 9:00 AM, Staff E stated she works Monday-Friday day shift with Resident #1. She stated the resident had been to the wound clinic inconsistently. She stated the resident is non-complaint and does as he chooses. Staff E stated she completes the prescribed wound dressing change Monday-Friday but admits she does not measure the wounds weekly as she should. Staff E stated she was to measure the resident's wounds every Wednesday on her shift but admits she does not assess and measure the wounds weekly. During an interview with Staff F/Administer on 5/6/24 at 12:45 PM, Staff F stated the nursing staff failed to perform weekly skin assessments as per facility policy and directed the nursing staff to examine every resident's skin condition on 5/1/24. As a result of the completion of the facility wide mandated resident skin assessments the nursing staff identified an additional 15 residents with impaired skin. During an interview with Staff B/Director of Nurses on 6/8/24 at 10:00 AM. Staff B stated the aides are to observe the resident's skin with cares and report areas of concern to the charge nurse. She stated with each bath the aides are to report areas of skin concerns by placing their findings on a bath sheet and handing it off to the resident's charge nurse. Staff B was asked for copies of bath sheets for Resident #1 but failed to provide them, stating she couldn't find them. The facility Skin Care: Management of Wounds and Pressure Injuries policy effective 6/20/2023 included: Policy: Wound management involves assessment and proper treatment of wounds to promote healing, minimize pain, and prevent infection. PROCEDURE: Assessment: The purpose is to evaluate wounds to determine appropriate treatment and response to the treatment. Visual assessment with every dressing change. Documented assessment at least weekly. Documented assessment includes: Date of onset/date updated Location, size, depth, stage, condition of surrounding skin, condition of wound bed, current treatment and response, family notification, physician notification, and dietary notification.

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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 0686 Level of Harm - 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** 19126 Based on clinical record review, staff and resident interviews, observations, and facility policy review, the facility failed to identify impaired skin for residents at high risk to develop pressure sores for 2 of 6 resident's reviewed (Residents #5 and #6). The facility reported a census of 85 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #5 had diagnoses which included Non-traumatic brain dysfunction, heart failure, diabetes, and dementia. The MDS revealed the resident required extensive assistance for personal hygiene and had total dependence on staff for toileting, moving about the facility via wheelchair, did not ambulate, and had incontinence of bowel and bladder. The MDS indicted the resident had moisture related damage due to incontinence and required treatments of ointments and creams. The resident had a Brief Interview for Mental Status score of 3 which indicated severe cognitive impairment. Review of the Care Plan dated 5/9/2023, informed staff the resident had a risk for skin breakdown due to diabetes and dementia. The Care Plan directed staff to monitor the resident's skin condition with cares, report redness and break down, and to provide skin treatments as ordered. Review of the yearly Braden Scale for Predicting Pressure Sore Risks dated 4/10/24 revealed Resident #5 had a score of 15 which indicated they were at risk for developing pressure sores. Review of Resident #5's Wound/Skin Healing Record dated 5/3/24 indicated the resident had 2-Stage 2 pressure injuries identified on this date in the coccyx region and the right buttock. The coccyx wound measured 2 cm x 0.5 cm x 0.1 cm depth without drainage and the right buttock measure 2.5 cm x 1 cm x 0.1 cm depth without drainage. The staff indicated the pressure areas were a Stage 2 which means the resident had partial thickness loss of the skin with exposed dermis. Observation on 5/8/24 at 9:30 AM revealed the resident in bed on her right side, propped up with a bed pillow. The pressure sore to the right buttock approximately the size of a quarter was non-reddened. The previously opened area to the coccyx appeared closed. Staff D/LPN indicated the areas appeared healed on this date. Staff E/LPN applied the prescribed treatments to both areas. Review of the Physician's Order Sheet dated 5/6/24 revealed the Primary Care Provider order Resinol External Ointment 55-2% to the buttock and coccyx area twice daily and as needed. Review of the nursing Progress Notes from 3/7/24 - 5/3/24 failed to reveal skin assessments completed by nursing staff. Review of the New skins found on Skin Sweep 5/1 - 5/3/2024 form provided to survey team on 5/6/24 included Resident #5 with pressure sores to her coccyx and right buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. According to the MDS dated [DATE] Resident #6 had diagnoses which included heart failure, malnutrition, and schizophrenia. The MDS indicated the resident had a risk to develop pressure sores and had moisture associated skin damage due to incontinence. The resident had occasional urinary incontinence and frequent bowel incontinence. The MDS revealed the resident had a BIMS score of 12 which indicated moderately impaired cognition, exhibited disorganized speech and had verbal and physical behaviors towards others. The resident required total assistant to move from bed to chair, did not walk, and needed substantial assistance with toileting. Review of Resident #6's Care Plan dated 4/5/23 and revised on 10/3/23 indicated the resident had a Stage 2 pressure ulcer on the right buttock due to impaired mobility and incontinence. The Care Plan directed the staff to assess the pressure ulcer for location, stage, size, presence of granulation tissue and epithelization, and condition of surrounding skin weekly. To monitor skin during cares and report any signs of further breakdown (sore, tender, red or broken areas) and to provide skin treatments as ordered. Review of the quarterly Braden Scale for predicting pressure sore risk assessment dated [DATE] revealed the resident had a score of 15 which indicated the resident at high risk to develop pressure sores. At the time of the assessment the resident did not have a pressure sore. Review of Resident #6's nursing Progress Notes fail to contain skin assessments or documentation of skin condition from 3/1/24 - 5/2/2024. Review of a Physician's Order dated 9/8/2023 directed the staff to apply Phytoplex Z-guard External Paste 57-17% to the residents buttocks topically every evening and night shift for redness to the buttocks. Review of a Wound/Healing Record dated 3/25/24 indicated the resident acquired a Stage 2 pressure ulcer to the right buttock on 6/3/2023. On 3/25/24 the staff considered the pressure sore healed but failed to continue to assess the resident's skin weekly as per policy. Review of a Wound/Skin Healing Record dated 5/2/24 revealed the resident acquired a Stage 3 pressure sore to the left buttock which measures 1 cm x 1.5 cm x 0.1 cm depth. During an interview with Staff E/LPN on 5/8/24 at 9:17 AM, Staff E stated Resident #6 had known skin impairments, she did not assess the resident's skin weekly and stated she should have had weekly skin checks completed. During an interview with Staff D/LPN on 5/6/24 at 1:00 PM, Staff D stated Resident #6 had a history of pressure wound to the buttocks. She stated it comes and goes, it is a chronic wound. Staff D stated the resident was resistive to cares and will not always allow staff to provide cares including wound cares. Observation attempted on 5/8/24 at 9:40 AM of the resident's pressure ulcer to his buttock. The resident became extremely agitated and refused to allow the Surveyor to view the pressure area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with Staff B/Director of Nurses on 5/8/24 at 10:00 AM. Staff B stated the aides are to observe the resident's skin with cares and report areas of concern to the charge nurse. She stated with each bath, the aides are to report areas of skin concerns by placing their findings on a bath sheet and handing it off to the resident's charge nurse. Staff B was asked for copies of bath sheets for Resident #5 but failed to provide them, stating she couldn't find any. The expectation for residents with healed pressure sores is for the nursing staff to measure and assess a residents pressure site for an additional 2 weeks after the staff determined the area is healed. The nurses are expected to complete the skin assessments every week as per the policy. During an interview with Staff F/Administrator on 5/6/24 at 12:45 PM, Staff F stated the nursing staff failed to perform weekly skin assessments as per facility policy and directed the nursing staff to examine every resident's skin condition on 5/1/24 - 5/3/2024. As a result of the completion of the facility wide mandated resident skin assessments the nursing staff identified an additional 15 residents with impaired skin, 3 of the 15 were labeled as pressure sore. Review of the New skins found on Skin Sweep 5/1/24 - 5/3/2024 form provided to the survey team on 5/6/24 included Resident #6 with a pressure related pressure sore to his bilateral buttocks. The facility Skin Care: Management of Wounds and Pressure Injuries policy effective 6/20/2023 included: Policy: Wound management involves assessment and proper treatment of wounds to promote healing, minimize pain, and prevent infection. PROCEDURE: Assessment: The purpose is to evaluate wounds to determine appropriate treatment and response to the treatment. Visual assessment with every dressing change. Documented assessment at least weekly. Documented assessment includes: Date of onset/date updated Location, size, depth, stage, condition of surrounding skin, condition of wound bed, current treatment, and response, family notification, physician notification, and dietary notification.