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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165331	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morning Sun Care Center	200 Washington Morning Sun, IA 52640

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 F 641 Accuracy of Assessments SS=E Based on clinical record review, staff interview, and Resident Assessment Instrument (RAI) Manual review, the facility failed to ensure accurate coding of anticoagulant medication, antiplatelet medication, antibiotic medication, and pressure ulcers on the Minimum Data Set (MDS) assessment for four of twelve residents reviewed for MDS accuracy (Residents #3, #11, #14, and #23). The facility reported a census of 23 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment, reflected Resident #3 took anticoagulant medication and did not take an antiplatelet medication. The Physician Order dated 8/17/21 documented, Aspirin EC Tablet Delayed Release 81 MG (milligram) with instructions to give 1 tablet by mouth one time a day related to paroxysmal atrial fibrillation (occasional irregular heartbeat in the upper chambers of the heart). Resident #3's March 2024 Medication Administration Record (MAR) lacked administration of an anticoagulant medication, and revealed she took an antiplatelet medication. 2. Resident #11's MDS assessment dated [DATE] a BIMS score of 14, indicating intact cognition. The assessment reflected Resident #11 took an anticoagulant medication and antiplatelet medication. The assessment lacked documentation Resident #11 received antibiotic medication. The Clinical Physician Orders reviewed on 4/9/24 included the following orders dated: a. 10/11/23 for Methenamine Hippurate Oral Tablet (antibiotic) with instructions to give 1 gram by mouth two times a day for a UTI (urinary tract infection) prophylaxis (prevention). b. Clopidogrel Bisulfate Oral Tablet 75 MG (milligram) with instructions to give 1 tablet by mouth one time a day related to heart failure. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's Medication Administration Record (MAR) dated January 2024 lacked documentation of receipt of anticoagulant medication. Per Resident #11's MAR, the resident received Methenamine Hippurate twice per day for the month of January and took Clopidogrel Bisulfate daily for the month of January 2024. 3. Resident #14's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS assessment lacked documentation Resident #14 took anticoagulant medication or antibiotic medication. The Clinical Physician Orders reviewed 4/10/24 at 12:48 PM included the following orders: a. Dated 11/14/23: Apixaban Oral Tablet 5 MG (an anticoagulant medication). Give 1 tablet by mouth 2 times a day related to chronic atrial fibrillation (irregular heartbeat). b. Dated 11/15/23: Doxycycline Hyclate Oral Tablet (antibiotic) 100 MG by mouth in the morning for community acquired PNA (Pneumonia), chronic suppression. Resident #14's February 2024 MAR included the following documentation: a. Apixaban Oral Tablet 5 MG (Apixaban) give 1 tablet by mouth two times a day related to chronic atrial fibrillation. - Documented as administered twice a day. b. Doxycycline Hyclate Oral Tablet (Doxycycline Hyclate) give 100 mg by mouth in the morning for community acquired PNA. - Documented as administered once a day. On 4/11/24 at 12:11 PM, the Director of Nursing (DON) acknowledged the facility followed the RAI (Resident Assessment Instrument) manual. When queried about documentation for Resident #3, the DON explained she only saw the current medication of aspirin. The DON explained she didn't see anything discontinued during that timeframe on March 7th. When queried about documentation listed above on Resident #11's MDS, the DON explained she received clarification about Methenamine after the fact, and acknowledged it needed to be on the MDS per guidance received. When queried about above findings for Resident #14, the DON explained she saw the same information. Review of the RAI Manual dated October 2023 documented the following: a. Antibiotic: Check to see if the resident received an antibiotic medication at any time during the 7 day look back period (or since admission, entry, or reentry if less than 7 days). b. Do not code antiplatelet medication such as aspirin/extended release, dipyridamole, or clopidogrel as an anticoagulant. 25855 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #23 MDS assessment dated [DATE] identified Resident #23 had a BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications. The MDS lacked Resident #23's other two pressure ulcers. The Nurse's Admission assessment dated [DATE] at 7:12 PM documented the following skin conditions for Resident #23: a. 3 pressure ulcers with the following measurements: - One Stage IV to the sacrum Length measured 3 cm (centimeters) Width measured 2.5 cm with no depth documented. - One Stage II to right thigh (rear) Length measured 2 cm Width measured 1.0 cm No depth documented. - One Stage II to right thigh (rear) Length measured 1.5 cm Width measured 1.0 cm No depth documented. The Narrative Notes had documentation of the following: Resident #23 observed with a sacral decubitus (pressure ulcer) dressing saturated with draining yellow drainage. The ulcer had pink tissue and looked moist. The outer area of the wound appeared yeasty on the skin. Resident #23 had open areas on her right upper back thigh. The note lacked description of the wounds on her right upper back thigh. Resident #23's MDS dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer with one unstageable pressure ulcer labeled as facility acquired. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications. The Skin Condition Note labeled late entry on 3/14/24 at 1:30 PM reflected the nurse assessed the sacral (lower back just above the buttock) and gluteal (buttocks) dressings. After cleaning the wounds with wound cleanser, the nurse measured the following: a. Sacral wound: 2.5 cm x 2.5 cm x 1.7 cm; dressing applied of collagen and mepilex b. Right gluteal fold (inner): 1.2 cm x 0.6 cm; dressing of medic honey applied and mepilex (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Right gluteal fold (outer): 1 cm x 0.5 cm; dressing of medi honey and mepilex applied. The Note lacked the label of each measurement (length, width, depth). On 4/8/42 at 9:54 AM Resident #23 sat in her recliner in her room with a pressure reducing cushion in the seat. Resident #23 reported she lived at the facility since December 2023 and had an open area to her bottom on her admission. She wore Prevalon (pressure reduction boots) boots to both feet, an air mattress to her bed which was properly inflated. An indwelling catheter bag hung in a dignity bag below bladder level without tubing touching the floor. She denied pain or discomfort at this time. On 4/10/24 at 9:09 AM Resident #23 sat in her recliner in her room. When the surveyor asked if she could observe her wound care, she reported she would rather not have the surveyor observe. Pressure reducing cushion noted underneath her and she wore Prevalon boots to both feet. The resident refused to allow the surveyor to make observations of the wounds. In an interview on 4/11/24 at 9:45 AM, the DON reported upon review of Resident #23's admission assessment, She explained she started it on 12/7/23, and documented one Stage IV pressure ulcer to the sacral area. She only remembered that pressure ulcer. It appeared the wound nurse added another entry dated 12/14/23, which identified the resident with 3 pressure ulcers. Upon review of Resident #23's admission MDS, she verified the MDS dated [DATE] identified her a Stage IV pressure ulcer. The DON explained reviewing the entry in the progress notes, she had difficultly identifying who added the measurements on the other Stage II pressure ulcers. She recalled she didn't stage pressure ulcers and asked the wound nurse to do so. When asked if Resident #23 developed a second pressure ulcer as the last quarterly MDS now identified her with an unstageable pressure ulcer, she reported Resident #23 did develop a second one, but unsure of the date. There are 2 open areas to the right gluteal. One is a deep tissue injury which was unstageable and that would be facility acquired. The other area to the right gluteal is shearing. Resident #23's had her current pressure ulcers on the sacral and the right gluteal areas. In an interview on 4/11/24 at 10:21 AM, the MDS coordinator upon review of the admission MDS dated [DATE], she verified the MDS identified Resident #23 with only one stage IV pressure ulcer with no other ulcers. Upon review of the quarterly MDS dated [DATE], she verified the MDS identified Resident #23 now with a facility acquired unstageable deep tissue injury. She based this on review of the last entry of the wound nurse's notes. She did not know what caused the deep tissue injury and verified it was not documented in the nurse's progress notes.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25855

Based on observation, record review, resident, and staff interviews, the facility failed to develop comprehensive care plans for two of twelve residents reviewed (Residents #14 and #23). The facility identified a census of 23 residents.

Findings include:

1. Resident #23's MDS dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer with one unstageable pressure ulcer labeled as facility acquired. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications.

The Nurse's Admission assessment dated [DATE] at 7:12 PM documented the following skin conditions for Resident #23:

a. 3 pressure ulcers with the following measurements:

- One Stage IV to the sacrum Length measured 3 cm (centimeters) Width measured 2.5 cm with no depth documented.

- One Stage II to right thigh (rear) Length measured 2 cm Width measured 1.0 cm No depth documented.

- One Stage II to right thigh (rear) Length measured 1.5 cm Width measured 1.0 cm No depth documented.

The Narrative Notes had documentation of the following:

Resident #23 observed with a sacral decubitus (pressure ulcer) dressing saturated with draining yellow drainage. The ulcer had pink tissue and looked moist. The outer area of the wound appeared yeasty on the skin. Resident #23 had open areas on her right upper back thigh. The note lacked description of the wounds on her right upper back thigh.

The Baseline Care Plan dated 12/7/23 lacked Resident #23's problem of pressure ulcers.

The Care Plan Focus initiated 12/20/23 and revised 3/26/24 identified Resident #23 had a nutritional risk related to a stage IV sacral pressure ulcer and her diagnosis of multiple sclerosis with a history of protein calorie malnutrition (not enough protein and calories absorbed by her body). The Care Plan lacked interventions to treat, assess, and/or prevent further pressure ulcers.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23's MDS dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer with one unstageable pressure ulcer labeled as facility acquired. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications. The Skin Condition Note labeled late entry on 3/14/24 at 1:30 PM reflected the nurse assessed the sacral (lower back just above the buttock) and gluteal (buttocks) dressings. After cleaning the wounds with wound cleanser, the nurse measured the following: a. Sacral wound: 2.5 cm x 2.5 cm x 1.7 cm; dressing applied of collagen and mepilex b. Right gluteal fold (inner): 1.2 cm x 0.6 cm; dressing of medic honey applied and mepilex c. Right gluteal fold (outer): 1 cm x 0.5 cm; dressing of medi honey and mepilex applied. The Note lacked the label of each measurement (length, width, depth). On 4/8/42 at 9:54 AM Resident #23 sat in her recliner in her room with a pressure reducing cushion in the seat. Resident #23 reported she lived at the facility since December 2023 and had an open area to her bottom on her admission. She wore Prevalon (pressure reduction boots) boots to both feet, an air mattress to her bed which was properly inflated. An indwelling catheter bag hung in a dignity bag below bladder level without tubing touching the floor. She denied pain or discomfort at this time. On 4/10/24 at 9:09 AM Resident #23 sat in her recliner in her room. When the surveyor asked if she could observe her wound care, she reported she would rather not have the surveyor observe. Pressure reducing cushion noted underneath her and she wore Prevalon boots to both feet. The resident refused to allow the surveyor to make observations of the wounds. On 4/11/24 at 8:57 AM, Staff A, Registered Nurse reported when a resident admits with an existing pressure ulcer, it should be included on the Baseline Care Plan and on the Comprehensive Care Plan. The MDS Coordinator is responsible for developing the Care Plan. She didn't know when the Care Plans should be completed after admission. Resident #23 did have a Stage IV pressure ulcer to her sacrum on admission. She thought Resident #23 had 2 other areas, but never had any on her legs, but on her bottom. She didn't know if Resident #23 had facility acquired ulcers. The Progress Notes should include the wound measurements, assessments, each week. The wound nurse usually documented them. She worked from 6 PM to 6 AM. The documentation should include measurements, appearance, drainage, treatment, and notification of doctor. The Care Plan should include the following Interventions a. Special mattress (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Cushion in her wheelchair c. Pillows to offload her from side to side d. Reposition frequently from bed to chair, and chair to bed e. Multivitamin. On 4/11/24 at 9:12 AM, when asked if a resident is admitted with an existing pressure ulcer, should that be addressed on the Baseline Care Plan, Staff B, Licensed Practical Nurse (LPN) responded she didn't know as she didn't do the Care Plans. When asked if pressure ulcers should be addressed on the Comprehensive Care Plan, she said she didn't have any knowledge of that. The MDS coordinator had the responsibility of developing the Care Plan. The MDS Coordinator at the time of Resident #23's admission is the current DON (Director of Nursing). When asked what was the time frame a problem should be identified on the Care Plan after admission, she replied she didn't know. When asked if Resident #23 had any pressure ulcers on admission, she responded Resident #23 had one to her sacral area and another open area to her hip which has healed since her admission. Staff B said any nurse could document on the pressure ulcer, the wound nurse, normally did the measurements, assessments, etc. She didn't know exactly what else should be documented as she didn't assess the wounds, because the RN did. On 4/11/24 at 9:45 AM, the DON explained when a resident admitted to the facility with an existing pressure ulcer, she expected the Baseline Care Plan and the Comprehensive Care Plan to include it. She added the MDS Coordinator is responsible for developing the Care Plan. She expected the Care Plan developed within 48 hours of admission. Common interventions she expected to see on a Care Plan for a resident with pressure ulcers would include: Nutrition Multivitamin, get the Dietitian, and the physician involved to get orders for extra protein, pressure reducing cushion, mattress, and turn them at least every 2 hours. She expected the nurse to document weekly on the wound. The nurse should measure and document the appearance, notifications completed, any changes, and treatments in a skin note in the progress notes. Resident #23 did have a pressure ulcer to her sacrum on admission, however, she couldn't recall if she had more than one pressure ulcer on admission. Upon review of Resident #23's admission MDS, she verified, she started the admission assessment. It appeared that the wound nurse revised the DON's note. The MDS did identify Resident #23 with one pressure ulcer, however, the wound nurse identified her with 3 pressure ulcers. The DON reported she left the note open for the wound nurse to complete as the DON didn't stage wounds. At the time Resident #23 admitted to the facility, she worked as the MDS coordinator, she thought Resident #23 only had one pressure ulcer to her sacral area. She had 2 open areas to her right gluteal fold, which she didn't believe were pressure ulcers. Resident #24's current pressure ulcer(s) were on the sacral and the right gluteal areas. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/11/24 at 10:21 AM, the MDS Coordinator reported when a resident is admitted with an existing pressure ulcer, the Baseline Care Plan and Comprehensive Care Plan should include it. The MDS is responsible for developing the Care Plan. They should start the Baseline Care Plan within 24 hours after admission. The common interventions she expected to see on a residents' Care Plan with a pressure ulcer would include: frequent repositioning at least every 2 hours, move from bed to chair to wheelchair, restorative care, pressure relieving device on the bed and chair. Treatments as ordered by the physician. Document wound assessments/measurements at least once a week. Upon review of the admission MDS , she verified Resident #23 only had one stage IV pressure ulcer. When asked if Resident #23 developed a second pressure ulcer, she reviewed the first quarterly MDS and verified it identified Resident #23 with one stage IV pressure ulcer and one current unstageable deep tissue injury. The tool used to develop the Care Plan would be the nurse's admission assessment. She couldn't verify if the second open area as a pressure ulcer, however, that it was classified as a deep tissue injury. And she couldn't find documentation of what caused the injury. In an interview on 4/11/24 12:04 PM, the DON provided timeline of Resident #23's wounds and explained the following: a. 12/7/23: admitted with Stage IV pressure ulcer to the sacrum and 2 stage II pressure ulcers to the right lateral thigh/hip. b. 12/14/23: area to right thigh/hip resolved c. 1/5/24: two new areas to the inner right gluteal fold and to the outer right gluteal fold identified as deep tissue injuries with the cause unknown. The Pressure Ulcer Risk Assessment and Documentation policy reviewed January 2011 instructed the assigned nurse to complete the Admission/Readmission Pressure Ulcer Risk Assessment Tool on new admissions and readmissions. Determine the factors/conditions that place the resident at risk for developing pressure ulcers, list any additional risk factors. Review risk factors and Interventions with the resident and/or responsible party. The assigned nurse will complete the Nursing Admission Assessment which includes factors/conditions that may place a resident at risk for pressure ulcer development. Communicate interventions to appropriate staff. Update the Care Plan and interventions as risk factors change. 45338 2. Resident #14's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #14's Care Plan lacked long-term antibiotic use. The Clinical Physician Orders reviewed 4/10/24 at 12:48 PM included an order dated 11/15/23 for doxycycline hyclate Oral Tablet (antibiotic) 100 MG by mouth in the morning for community acquired PNA (Pneumonia), chronic suppression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 11/15/23 documented the following antibiotic medication for the resident: Doxycycline Hyclate Oral Tablet with instruction to give 100 mg (milligram) by mouth in the morning for community acquired PNA (Pneumonia), chronic suppression. Review of Resident #14's MARs revealed he took Doxycycline in the months of November 2023, December 2023, January 2024, February 2024, March 2024, and April 2023. On 4/11/24 at approximately 10:50 AM when queried if she expected the Care Plan to include prophylactic antibiotics, the MDS Coordinator replied yes. When queried if Resident #14 had this on his Care Plan, MDS Coordinator acknowledged she didn't see it. On 4/11/24 at 12:09 PM when queried if long term prophylactic antibiotics should be on the Care Plan, the Director of Nursing (DON) acknowledged yes.