STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165427	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newton Health Care Center	200 South Eighth Avenue East Newton, IA 50208

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 record review, staff interviews and policy review, the facility failed to accurately document pressure ulcers for 1 of 3 residents reviewed (Resident #1). During record review of this resident's skin areas, the facility didn't assess the skin when doing the daily skilled assessments. The resident was admitted to the hospital with a decubitus ulcer (a pressure sore, bedsore, or pressure ulcer, is a localized area of skin damage caused by prolonged pressure on the skin. The pressure reduces blood flow to the area, which can lead to tissue damage and death.) to the buttocks. The facility reported a census of 45 residents. Findings include: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: (continued on next page)

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	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. Resident #1 hospital discharge with admitted [DATE] documented the resident had diagnoses of congestive heart failure, generalized weakness, osteoporosis, and hypertension. The resident was admitted for malaise and not acting himself per family Review of the Weekly Nursing Skin Assessment for Resident #1 on 8/23/24 documented shearing on the coccyx measuring 3 centimeters (cm) by 2 cm with a depth of 0.2 cm. The right lower leg (rear) had an abrasion measuring 18 cm by 18.5 cm with a depth of 0.1 cm. The left lower leg (rear) had an abrasion measuring 5.0 cm by 1.0 cm with a depth of 0.1 cm. Progress Note for Resident #1 on 8/23/24 at 16:04 PM documented the resident noted to have redness, pain, swelling and warmth to left lower leg . Call made out to no call for recommendations. Shearing is noted on the back of calves. Left side 5.0 cm x 1.0 cm x 0.1 cm Right side 18.0 cm x 18.5 cm. Left dorsal hand bruise 9.0 cm x 9.0 cm dark purple in color. Scabs noted to bilateral lower legs right side from knee down #1 1.0 cm x 0.7 cm #2 1.0 cm x 1.0 cm #3 1.0 cm x 0.3 cm #4 0.8 cm x 0.4 cm. Record review for Resident #1 revealed Daily Skilled charting on 8/24/24 18:13 PM documented there are no open areas/skin issues at this time on assessment. Daily Skilled charting on 8/24/24 at 5:02 AM documented there are no open areas/skin issues at this time on assessment. Daily Skilled charting on 8/23/24 at 4:20 PM documented here are no open areas/skin issues at this time on assessment. Daily skilled charting on 8/23/24 at 2:37 AM documented here are no open areas/skin issues at this time on assessment Review of the facility Progress Notes dated 8/24/24 to 8/27/24 lacked documentation that a followup was completed to obtain physician orders for the skin issues discovered on admission. Review of the Hospital Progress Note for Resident #1 dated 8/24/24 documented the resident came to the hospital with a stage 2 bilateral buttocks decubitus ulcers (stage 2 decubitus ulcer, also known as a pressure ulcer, is a shallow, open wound or blister that can appear on the skin. It's caused by damage to the epidermis or dermis, the skin's outer and deeper layers, respectively). An unstageable wound to both the right and left posterior lower leg/heel. Unstageable wound starting at right upper heel and extending upwards several inches with blue-green drainage. Left upper posterior heel extending upwards sever inches denuded with unstageable wound with yellow hardened wound bed. Resident on Intrvenous (IV) Clindamycin for wound infection and cellulitis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 1:20 PM, Staff A, Registered Nurse (RN) 1:20 PM reported on Wednesdays she does weekly skin assessment. During the week the nurses put notes in the chart if it is a new skin area or worse when they are working. The CNAs will also fill out a shower sheet that documents any skin issues noted on shower days. She reported she had some training on skin assessments and had papers she refers to for staging of pressure ulcers. She reported Resident #1 had open skin areas to his bilateral lower legs but not on the heel. She reported they did an intervention of putting the legs up on pillows but it was hard to keep them on the pillows due to twitching frequently. She was not sure why the nurses were charting he had no skin issues when he had skin concerns noted on 8/23/24. During an interview on 8/28/24 at 8:15 AM Staff B, RN reported on daily skilled assessment if a resident would have skin issues they would note it there because the nurse should be doing a full skin assessment. She verbalized that she physically looks at the skin when she does any skilled assessment. She reported Resident #1 did not move around much that she is aware of. During an interview on 8/28/24 at 8:26 AM Staff D, Certified Nursing Assistant (CNA) reported that Resident #1 would get up to the toilet otherwise never really got up much. She reported she told the nurse on the 17th of August that Resident #1's bottom was really red and close to opening up. During an interview on 8/28/24 at 9:13 AM Staff C, Assistant Director of Nursing (ADON) reported that if a resident on skilled care has any skin concerns, she would document it on the skilled assessment She verbalized she would document it on the bottom of the assessment. If the skin concern was new then she would send a fax out to the physician on the area. She reported Resident #1 never really moved around much that she is aware of. During an interview on 8/28/24 at 9:45 AM, the Director of Nursing reported she did half the skin assessment on Resident #1. She reported when she came to work on 8/23/24 the Minimum Data Set (MDS) coordinator reported Resident #1 had open areas noted on his bilateral lower legs. She did the skin assessment on them. She reported on the Daily Skilled assessments nurses should have done a full head to toe assessment that includes checking the skins. If the skin is a new area then staff should measure the skins and notify the family and physicians. They have standing orders for treatments until the physician is able to see it. The facility policy titled Wound Documentation Guidelines with a revised date of April 2017 documented a pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.