STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Drumm Retirement Center	5837 Winwood Drive Johnston, IA 50131

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 - 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** 34817 Based on record review, staff interviews, and policy review the facility failed to provide the care, interventions, and services to prevent the development of a pressure sore for 2 of 6 residents sampled as at risk for pressure ulcer development, (Resident #1 and #2). The facility reported a census of 116. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: 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: 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. (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 - Actual harm Residents Affected - Few	1. The admission MDS assessment dated [DATE] revealed Resident #1 admitted to the facility on [DATE] and had diagnoses of septicemia, MRSA (methicillin resistant staphylococcus aureus) (a bacterial infection), multi-drug resistant organism, and dementia. The MDS documented the resident had a risk for pressure ulcer development but had no pressure ulcers or skin issues during the assessment period. The MDS indicated the resident took an antibiotic during the 7-day look-back period. The MDS documented the resident required substantial to maximum assistance of staff for bed mobility and transfers, and had incontinence. The care area assessment triggered a category for pressure ulcer. The Care Plan initiated on 5/28/24 revealed the resident at risk for skin breakdown due to impaired mobility, incontinence, and high-risk medication use. The resident also required assistance with activities of daily living such as transfers and bed mobility. A focus area added to the Care Plan on 6/14/24 revealed the resident had an actual skin breakdown and classified the left and right heels had an unstageable deep tissue injury, and the right buttock had a skin tear. The Care Plan initiated 5/28/24 directed staff to: o Reposition and turn the resident in bed. o Provide assistance of one for transfers. o Administer medications and treatments as ordered. o Ensure a pressure reducing cushion in the chair, and a pressure relieving mattress on the bed. o Consult a wound care specialist as needed initiated 6/12/2024. o Assess the wound for signs or symptoms of infection such as redness, drainage, and odor initiated on 6/12/2024. o Administer antibiotics as ordered for bilateral heel wounds initiated on 6/14/2024. A CHI Admission assessment dated [DATE] indicated the resident's skin integrity intact. A CHI Skin One Time Observation Tool assessment dated [DATE] revealed the resident had intact skin (no abnormalities). The Braden Scale (used for predicting pressure sore risk) dated 5/17/24 documented the resident had a risk for pressure sore development. A Skin and Wound evaluation dated 6/11/24 revealed the resident had a new skin tear measuring 1.9 centimeters (cm) x 1.7 cm. The assessment lacked documentation of the wound location. The Medication Administration Record (MAR) dated 6/1/24 to 6/30/24 revealed the following orders: a. Bactrim (antibiotic) by mouth (PO) two times a day (BID) for 10 days for bilateral heel wounds started on 6/12/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. Portable 2-3 view x-ray of bilateral heels to rule out osteomyelitis ordered on 6/12/24 due to acute wounds to heels. c. Labs ordered on 6/13/24 due to resident's signs and symptoms of infection. The Treatment Administration Record (TAR) revealed the following: a. Reposition the resident per facility protocol and off-load wound every shift started on 6/12/24 at 7:00 AM. b. Prevalon boots to bilateral lower extremities at all times as the resident tolerated every shift started on 6/12/24 at 3:00 PM. c. Cleanse bilateral heels and apply betadine-soaked gauze pads, ABD (a large dressing) pad, kerlix, and tape in place daily for wound management started on 6/13/24 at 7:00 AM. d. Apply Triad paste to open wound on right buttock and cover with optifoam dressing daily started on 6/13/24 at 7:00 AM. e. Air mattress setting at 350. Check air mattress for correct setting and ensure it functioned properly each shift started on 6/13/24 and 3:00 PM. The Progress Notes revealed the following: a. On 5/17/2024 at 11:49 PM, resident admitted to the facility at 3:00 PM. Resident alert and oriented to time, person and place. Skin intact. Vital signs: blood pressure (BP) 135/76, temperature (T) 98.0, pulse (P) 75, respirations (R) 18. b. On 5/21/2024 at 10:16 PM, skin color normal. Skin intact with no abnormalities. c. On 6/11/2024 at 6:44 AM, a 2 cm x 2 cm skin abrasion noted on the resident's coccyx during cares. Triple antibiotic and ABD dressing applied. Resident repositioned to the lateral side to relieve pressure from coccyx. Resident did not seem to have pain during cares. d. On 6/12/2024 at 8:29 AM, the resident's skin assessed and a treatment performed to his peri-rectal area. Resident had the following new skin areas: 1). A 5.0 cm x 4.8 cm dark purple area with a white center on the left heel. 2). A 4.5 cm x 2.4 cm dark purple area on the right heel. Skin intact but not blanchable to either site. The resident denied pain. Heel protector boots placed and an air mattress ordered. At 10:34 AM, physician (Dr) at facility. New orders for wound care consult regarding heel wounds, bactrim ordered BID for 10 days for wound management, and x-ray of bilateral heels ordered to rule out osteomyelitis. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 3:20 PM, x-rays of bilateral heels obtained. Results pending. At 5:54 PM, an alternating air mattress delivered and set up on the bed. At 7:29 PM, x-ray results showed no acute fracture or dislocation or bony destruction to suggest acute osteomyelitis to bilateral heels. e. On 6/14/2024 at 3:26 PM, per hospital report, resident admitted for septic shock and respiratory failure. Resident currently intubated. A Physician's Encounter note dated 6/12/2024 at 12:00 AM, documented on 6/12/24 at 7:21 PM, revealed a follow-up on the resident's declining functional status and bilateral heel wounds on 6/12/24. Nursing staff noticed what appeared to be deep tissue injuries to the bilateral heels. The resident reported his feet are not painful. A family member reported she noticed some discoloration on his feet, particularly on the right foot. The physician documented the heel wounds as fairly extensive pressure-induced deep tissue damage with purulence in the center. X-rays of the bilateral heels ordered to evaluate for possible osteomyelitis. Started on Bactrim BID for 10 days due to concerns about potential infection in the heels. Wound care consulted. Nursing staff shall ensure proper offloading and pressure relief for the affected areas. An Origami Risk (incident) Report for Resident #1 revealed on 6/13/2024 at 10:00 AM, a skin assessment revealed the resident had the following new areas: 1. A 5.0 cm x 4.8 cm dark purple area with a white center on the left heel. 2. A 4.5 cm x 2.4 cm dark purple are on the right heel. Skin intact but not blanchable to either site, and surrounding skin pink/blanchable. The resident denied any pain or discomfort when areas palpated. Heel protector boots put in place. Director of Nursing (DON) notified and an air mattress ordered 6/13/24. A physician expected to visit the facility on 6/14/24 to assess the areas for appropriate dressings and further orders. The Braden scale indicated the resident at a high risk for pressure ulcers. A reviewer follow-up determined the areas as a deep tissue injury (DTI). A Stop, Think, Act, Review (S.T.A.R.) universal skill could have been used to prevent this incident from occurring. Immediate actions included: Wound areas measured and treatment initiated. Heel boots on at all times. Alternating air mattress ordered for the bed. A Provider's Encounter note dated 6/13/2024 at 12:00 AM that was signed on 6/14/24 at 3:07 PM revealed the provider saw the resident on 6/13/24 but the resident had a decline in status, fever, and hypoxia. Order to send resident to the Emergency Department (ED) for evaluation. An E-interact Change in Condition form dated 6/14/24 revealed the resident had a sudden change in level of consciousness and unresponsive, and required more assistance with ADL's started on 6/14/24. Vital signs included B/P 68 / 50, P 155, R 24, T 101.9, pulse oximetry (PO) 73%. Physician and resident representative notified. Resident sent to the ED. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An E-interact Transfer form dated 6/14/24 at 4:00 PM revealed the resident sent to the ED due to abnormal vital signs (low b/p, elevated temperature and elevated pulse), pain in right heel, and pressure ulcers to his heels. The ED Provider note dated 6/14/24 at 12:22 PM revealed the resident presented to the ED with a B/P 58/42, T 99.0, P 172, R 30, PO 95 %. The resident had wounds present with ulcers on his bilateral heels. The provider's clinical impression/diagnoses included: septic shock (a life-threatening condition due to an infection causing low blood pressure and organ damage) and acute respiratory failure with hypoxia (lack of oxygen to the tissues). In an interview on 6/25/24 at 9:30 AM, Staff D, Registered Nurse (RN) reported she used an app on the IPAD for tracking wounds. A dot placed by the wound, and when she took a picture of the wound, the program calculated the wound measurements. Staff D stated since they had been unable to find the dots, the wound provider measured the resident's wounds. In an interview on 6/25/24 at 11:45 AM, Staff E, Certified Nursing Assistant (CNA), stated she looked at the resident's Care Plan in the Plan of Care (POC) to know what cares or things needed done for the residents. Staff E reported she placed a sheet under the resident in bed for lifting if a resident had a risk for pressure sores. The resident may also use an air mattress. She checked on the resident every 2 hours to see if they needed anything. Staff E reported she documented in POC whenever she transferred or did something with the resident. In an interview on 6/25/24 at 12:00 PM, Staff F, CNA, reported she got updates from the nurse and other staff on what she needed to do for the residents. A booklet at the nurse's station had information about new admissions such as how a resident transferred, if the resident had incontinence, and things like that. She didn't know who updated the book. Staff F stated the electronic POC not as reliable because the information not updated as often. Staff F reported a resident needed repositioned if a resident at risk for pressure ulcer. She rolled the resident onto their side as tolerated, then shifted the resident onto the opposite side the next time she checked on the resident. Boots placed on the resident's feet if the resident had a sore on their feet or heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 6/25/24 at 1:55 PM, Staff C, Licensed Practical Nurse (LPN), reported skin assessments performed by the nurses weekly on each resident and documented on the MAR. A Braden Scale assessment done when a resident admitted to determine their level of risk for pressure ulcers. Staff C also reported a total body assessment completed and documented in the EHR. At the bottom of the form, staff documented 0 if no new skin issues, or indicated the number of new skin issues found. Staff C reported if a resident is at risk for pressure ulcer and had incontinence, she started house barrier cream, and let the DON know if the resident needed an alternating air mattress. If the resident at risk or had breakdown, then heel boots applied or heels floated on a pillow. Staff C stated if a resident had a wound, she documented in the Nurse's Note, notified the family and Dr., and filled out an incident report. Staff C stated she helped follow up on pressure ulcers/wounds whenever Staff D was off. Staff C stated a little dot placed by the wound, a picture taken, and the program calculated the measurements of the wound. Since they haven't been able to find the little white dots, a manual measurement done instead using a paper measuring tool. She communicated in report to the CNA's any new skin areas, and interventions or what they needed to do for the resident. Staff C reported only one nurse with 3 CNA's on Central (skilled unit) Hall. The residents' acuity levels were higher and there were a number of treatments to do. Several residents needed a hoyer lift for transfers and some residents needed help with eating. Staff not getting residents up because they don't have time and they don't have enough help, and the residents don't get repositioned like they should. She confirmed she had noticed residents with a lot of skin issues. Staff C stated staff had to choose if they were going to change someone or do something else. Staff C reported she was the one who found the wounds on Resident #1's heels when she went to do a treatment on his bottom. When she rolled him over to do the treatment, she noticed the wounds on his heels. One wound was the full size of his heel, and had swelling and a fluid-filled blister. The fluid did not appear clear, it was black. If she took a pin and popped it open, the skin under it would be necrotic. The resident didn't have an air mattress on the bed and he had no heel boots on the day she found wounds on his heels. She let the DON know and the air mattress was delivered the same day. She called the Dr and started treatment on his heels. In an interview on 6/25/24 at 2:30 PM, Staff G, RN, reported staffing could be better. One nurse for 30 residents is a lot. Staff get pulled to work in other areas when other units are short staffed. Staff not able to get residents up or provide the assistance they needed. In an interview on 6/25/24 at 3:10 PM, the wound Dr. reported the interventions put into place depended on the resident and if a resident at risk for pressure ulcers. If a resident had a Stage 2 pressure ulcer on the feet/heels then heel boots should be placed. In an interview on 6/26/24 at 9:15 AM, Staff H, RN, reported a head to toe skin assessment for certain residents assigned each day to the day and evening shift nurses. Skin assessments documented in the EHR under the full body assessment. She documented any skin concerns or wounds on the skin & wound assessment. Boots applied if a resident had a risk for pressure sores or a history of pressure ulcer on the heels. An air mattress placed on the bed and resident frequently repositioned if the resident had a wound/skin area on the sacral area. Staff H reported things don't get done when they are short-staffed. There are delays, residents don't get positioned timely and not changed as frequently, and then pressure ulcers developed. Staff D reported they do the best they can, but only have 2 nurses or 1 nurse and 1 CMA for 60 residents. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 6/26/24 at 3:20 PM, Staff J, RN, reported the nurses made recommendation on positioning devices if a resident at risk for pressure ulcer. He called the DON whenever a skin concern/area found. He got permission to use boots, and he may get an air mattress depending upon if the resident had a wound or risk for skin breakdown. He would also elevate legs on pillows to float heels if a resident not able to position themselves in bed. Staff J reported Resident #1 required staff to check on him. He didn't remember to use the call light. Staff checked on him every 2 hours on the night shift. They elevated his extremities on a pillow because he was in bed most of the time. In an interview on 6/27/24 at 2:15 PM, the surveyor asked the Administrator what the facility had done to improve and address the repeat deficiencies from the most recertification survey and prior surveys included pressure ulcer development. The Administrator responded he had been the Administrator at this facility since 3/2024, and he couldn't speak for prior Administration. They continued to do audits and staff education monthly since he started in 3/2024. He implemented a PIP (Performance Improvement Plan) on 4/2024, and put in some action plans in the past month. They made a targeted effort and are strategically working with staff to be successful to learn what needed to be done. The Administrator stated he is not a nurse but thought a lot of skin concerns were related to moisture, some residents refuse to eat or drink, and the resident's skin integrity already compromised from their hospital stay. A facility's policy for Pressure Injury Prevention and Management implemented 10/24/22 revealed the facility is committed to the prevention of avoidable pressure injuries and provision of treatments and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Evidence-based interventions for prevention implemented for all residents assessed at risk for pressure injury or who had a pressure injury present. Basic, routine care interventions included: pressure redistribution such as repositioning, protecting or offloading heels, exposure to moisture minimized, skin kept clean, and nutrition maintained. Interventions documented on the care plan and also communicated to all relevant staff. 2 The admission MDS assessment dated [DATE] revealed Resident #2 had diagnoses of stroke, hemiplegia (paralysis on one side), diabetes, malnutrition, and adult failure to thrive. The MDS documented the resident had a risk for developing a pressure ulcer but had no pressure ulcers or skin issues. The resident had incontinence, required substantial to maximum assistance for bed mobility, and had dependence on staff for transfers. The MDS assessment 4/23/24 revealed the resident had a Stage 4 pressure ulcer to the sacral region. The MDS documented the resident had incontinence, required substantial to maximum assistance for bed mobility, and had dependence on staff for transfers. The MDS assessment dated [DATE] revealed the resident discharged to the hospital and a return to the facility anticipated. A Baseline Care Plan dated 1/18/24 revealed the resident had no skin alterations. The Care Plan initiated on 1/29/24 revealed the resident had a risk for skin breakdown due to left hemiplegia, diabetes, immobility, incontinence, and malnutrition. The resident required assistance of two staff for transfers and to reposition and turn in bed. The Care Plan directives included the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	o Administer treatments as ordered and monitor for effectiveness. o Use a pressure reducing cushion in the chair and a pressure reducing mattress on the bed. A Care Plan revision on 3/29/24 included a low air loss mattress. The Care Plan revised on 4/18/24 revealed the resident had an actual skin breakdown and blistering on her lower back. The staff directives included: o Consult a wound care specialist as needed. o Monitor for wound healing and notify the physician if no improvement. A Care Plan focus area initiated 4/26/24 revealed the resident had a Stage IV pressure ulcer to the sacrum. The staff directives included to encourage the resident to reposition frequently (Initiated 4/26/24). A CHI Admission assessment dated [DATE] indicated the resident's skin intact. A CHI Skin One Time Observation Tool assessment dated [DATE] revealed the resident had intact skin (no abnormalities). The One Time Skin Observation Took assessment dated [DATE] documented a new skin concern, indicating a medium fluid-filled intact blister to Resident #2's upper mid-vertebrae. The Braden Scale dated 1/18/24 documented the resident had a moderate risk for pressure sore development. The Braden assessment dated [DATE] revealed the resident had a high risk for pressure ulcer development. The Skin and Wound assessments revealed the following: On the left ischial tuberosity: 2/6/24 MASD 1.9 cm x 0.9 cm 2/13/24 MASD 0.4 cm x 0.4 cm 2/20/24 MASD 1.4 cm x 0.6 cm; Treatment: Triad paste 2/27/24 MASD 1.1 cm x 0.9 cm 3/5/24 MASD 0.4 cm x 0.4 cm 3/12/24 MASD 1.3 cm x 1.1 cm 3/19/24 MASD 1.6 cm x 1.2 cm 3/26/24 MASD 1.4 cm x 0.7 cm 4/2/24 MASD 1.7 cm x 1.0 cm (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4/9/24 Stage 3 pressure area (in-house acquired) measured 5.7 cm x 3.2 cm 4/16/24 Stage 3 pressure area 6.7 cm x 3.5 cm 4/23/24 Stage 4 pressure ulcer 3.9 cm x 2.8 cm. Wound deteriorated. Wound specialist notified. 4/30/24 3.9 cm x 3.1 cm x 0.3 cm 5/7/24 3.6 cm x 2.4 cm On the left lower back: 4/16/24 A blister on the left lower back measured 0.3 cm x 0.1 cm The Treatment Administration Record (TAR) dated 3/1/24 to 4/30/24 revealed the following: a. Apply Triad paste to left buttock BID until wound healed started on 2/5/24 at 6:45 PM and discontinued on 3/31/24. b. Apply Triad paste to bilateral buttocks for BID started on 3/31/24 at 8:00 PM c. Check air mattress each shift to ensure air mattress plugged in, functioning properly and at the correct setting for skin protection started on 3/28/24 at 11:00 PM. d. Apply skin prep to fluid filled blister on left side of back (mid rib cage) started on 3/20/24, and discontinued on 3/29/24 at 4:56 PM. e. Apply bacitracin to site, cover with protective dressing daily and PRN for compromised skin area started on 3/30/24 at 7:00 AM and discontinued on 4/13/24. f. Apply calcium alginate to buttocks wound bed and a foam dressing to the sacral area daily started on 4/14/24 at 7:00 AM and discontinued on 4/24/24. g. Apply santyl and calcium alginate to the wound bed, then apply a sacral foam dressing daily started on 4/25/24 at 7:00 AM and discontinued on 5/7/24. An Origami Risk (incident) Report for Resident #2 dated 3/19/24 at 2:00 PM revealed a medium size intact fluid-filled blister noted to the back (posterior rib cage). No signs or symptoms of infection observed. Treatment orders obtained and education provided to the resident about frequent re-positioning. No incident report provided by the facility for the left ischial tuberosity skin concern. A Notice of Resident Transfer form dated 5/8/24 revealed the resident transferred to the hospital for evaluation of a wound and abnormal labs. Review of the Progress Notes revealed the following: a. 1/18/24 at 10:49 PM, resident admitted to facility. Skin intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. 2/25/24 at 11:55 PM, Skin assessment completed and no new skin issue noted. c. 3/29/24 at 5:00 PM, an open skin area on the left side of resident's back just below the armpit. The blister on the left side of her at the mid rib cage now open. Dr. notified. New orders received for bacitracin and protective dressing daily and PRN until resolved. d. 4/13/24 at 9:36 PM, wound bed and size of wound on bottom had deteriorated. Wound bed reddish/yellow in color and had clear drainage. Area tender when touched. New orders received to cleanse bilateral buttocks, apply calcium alginate to wound bed, and apply a sacral foam dressing daily until the area healed. e. 5/7/24 at 5:04 PM, open area on back measured 3 cm x 2 cm. Triple antibiotic ointment applied and area covered with a gauze. f. 5/8/24 at 7:15 PM, Dr assessed resident at approximately 12:30 PM. Resident unresponsive to questions but responded to pain. Face is cold and clammy but extremities warm. Dr assessed wound to sacrum. No signs of infection or odor noted. No drainage observed when removed the packing. T: 100.6, B/P: 42/39, P 119, unable to obtain pulse ox reading. Resident sent to the ED. g. 5/9/24 at 10:47 PM, hospital nurse reported the resident passed away at 6:52 PM. In an interview on 6/25/24 at 1:55 PM, Staff C, LPN, confirmed Resident #2 did not have a wound when she came to the facility. Staff C reported the resident had started to decline prior to going to the hospital. She was bed ridden, used a hoyer for transfers, and staff had to help feed her. It was the resident's preference to stay in bed because it hurt her to get up. She started to get skin breakdown on her bottom. She offered to send the resident to the hospital but a family member didn't want her to go to the hospital at that time. In an interview on 6/26/24 at 9:15 AM, Staff H, RN, reported Resident #2 used a hoyer and required assistance of staff for transfers and bed mobility. The resident developed a pressure sore while at the facility. A treatment was started. The wound Dr saw her. Staff H reported when they are short-staffed things don't get done. There are delays in residents not getting positioned timely and they don't get changed as frequently. Staff H confirmed residents then developed pressure ulcers. Staff D reported they do the best they can, but only have 2 nurses or 1 nurse and 1 CMA (certified medication aide) for 60 residents. In an interview on 6/26/24 at 3:20 PM, Staff J, RN, reported Resident #2 was bedbound and needed assistance with everything. She had weakness on one side, and she liked to [NAME] on one side. She complained of pain whenever they positioned her onto her left side. They checked and changed the resident. She had a wound on her bottom and had treatments provided to the area.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34817 Based on observations, resident, family, and staff interviews, record review, facility assessment, and policy review, the facility failed to provide sufficient staff to meet the residents' needs for cares and answer call lights timely for 2 of 3 nursing units. The facility reported a census of 116 residents. Findings include: Observations revealed the following: a.On 6/20/24 at 11:55 AM, no staff in the dining room with resident. Residents seated at two assistive table. A family member assisted a resident with feeding. At 12:02 PM, a staff person brought one of the residents at the assistive table a tray of food and began to assist the resident with eating. The staff member then assisted three residents, spooning food into their mouths and provided beverages. The staff member sat on a stool and wheeled around the table, and fed the residents. At 12:27 PM, the Administrator, Director of Nursing (DON), and Social Worker passed meal trays and answered call lights on the [NAME] halls. On the [NAME] (200) halls: b.On 6/24/24 8:00 AM 4 call lights on. On 6/24/24/ 8:24 AM all call lights off Call light on a total of 24 minutes. c.On 6/26/24 at 2:35 PM, 3 call lights on On 6/26/24 at 2:50 PM, 5 call lights on On 6/26/24 at 2:58 PM, Staff A, Registered Nurse (RN) walked down the hall and checked on a resident who had her call light on. At the time, the Administrator walked out of the DON's office and down the 200 hall, entered a resident's room where a call light was on and asked the resident what she needed. Another staff person (CNA) walked down the South Hall (on the [NAME] Unit) and responded to another resident's call light. Call light on a total of 23 minutes d. On 6/24/24 8:12 AM several trays with covered plates on a wheeled cart located on the 200 hallway. The trays had not been delivered to the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 8:25 AM, the Administrator pushed the cart with room trays down the [NAME] middle hallway and began to deliver meal trays to the residents in their rooms. At 8:30 AM, the Staff Development Manager and Administrator delivered room trays to residents on the [NAME] middle hall. The Staff Development Manager reported she worked the night shift but stayed over to help on 6/24/24 AM. At 8:33 AM, the DON delivered room trays along with the Administrator. At 8:40 AM, meal trays delivered except for one resident's tray. During confidential resident interviews that began on 6/20/24 - 6/26/24, 4 of 5 interviewable residents reported the facility didn't have enough help and were short-handed, especially on the night shift. The nursing staff and aides always seemed busy. The residents reported it took 30 minutes to 2 hours before someone responded to their call light. It was rarely under 15 minutes. The residents reported it depended upon how many staff worked, the time of day, and how long it took for staff to answer their call light. One resident reported since she required the assistance of two staff, it took longer to find staff to help her. One resident stated he wanted to get up by 6:00 AM but staff didn't get him up until after 7:20 AM on 6/24/24. Two of five residents voiced fear of retaliation by facility staff, and expressed dissatisfaction about the service they got for the amount of money people pay to stay at the facility. One resident stated the CNA's (certified nursing assistants) seemed too busy, distracted, and forgetful. Staff forgot to empty the bedpan and left soiled linens on the floor. A resident stated she thought the facility tried to replace staff but not always. Administration staff don't usually jump in to help but the residents had seen them helping whenever State in the building. A resident reported when family called the facility, they were placed on hold, but then no unit staff picked up the phone. One resident reported staff put her in bed at 2:00 PM because they told her if she doesn't go to bed at that time, they won't have staff to put her in bed. She ended up in bed until the staff got her up the next AM. The resident reported she didn't get repositioned when the facility was short-handed. During confidential family interviews on 6/20/24 at 11:43 AM and 6/25/24 at 11:04 AM, a family member reported staff didn't get the residents up for meals like they were supposed to and the resident lost a lot of weight because they didn't assist him/her with feeding. The resident got a bed sore and infection. Another family member reported she didn't think the facility had enough help. The resident fell and had to go to the hospital. The family member felt staff needed to be more on top of answering the call lights. It took more than 15-35 minutes to get someone to help her loved one. In an interview on 6/24/24 at 8:05 AM, Staff B, Licensed Practical Nurse (LPN) reported only 3 CNA's on 6/24/24 for 61 residents. Staff B reported 3 CNA's not enough and residents don't receive the care they need. The staff don't get residents up because many of the residents needed two staff for assistance and transfers. Sometimes they had an uncertified nursing assistant (NA), but the NA had limitations on what they could do. The NA couldn't do cares, transfers, and many of the things a certified aide could do. Staff B stated she talked to management about staffing but they don't want to pay the staff overtime or use agency staff. The schedule looked like they had staff but the schedule was not accurate. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 6/25/24 at 12:20 PM, an ancillary staff member reported residents voiced concerns about waiting 2 hours for their call light to get answered. One resident reported she sat on a bedpan for 2 hours. The facility was always short-handed and needed more help. The facility only staffed one CNA on each hall but there are alot of residents. The CNA's asked about staffing coverage needed and offered to come into help but On-shift showed the facility as fully staffed. However, the reality is staff not on the schedule. People also called in all of the time. The ancillary staff member confirmed the Executive Director, management team, and the front office staff rarely answer call lights but she saw them answer call lights and pass room trays whenever State was in the facility. In an interview on 6/25/24 at 1:55 PM, Staff C, LPN, reported only 1 nurse and 3 CNA's assigned on Central Hall. [NAME] Hall only had 3 CNA's on 6/23/24 for 60 residents. The load of residents is heavy and several residents required two staff to get them up. The nurse passed medications, provided treatments, performed assessments, etc. The resident acuity level is high, and several residents needed a hoyer lift for transfers, required lots of treatments/medications, and some residents needed assistance with eating. Staff C stated staff not getting residents up because they don't have time, and there's not enough help. It came down to choosing to change someone or feed someone. Staff C relayed she noticed residents didn't' get repositioned like they should, had more skin issues, weight loss, and a decline in their ability to do things whenever staffing levels reduced. Staff C stated leadership concerned about the budget and won't use agency or give incentives for staff to pick up shifts. Office staff (except for the Administrator) picking up meal trays and answering call lights was rare unless State in the facility. In an interview on 6/25/24 at 2:30 PM, Staff G, Registered Nurse (RN), reported she thought staffing could be better. She was assigned as the only nurse for 30 residents. Sometimes have CMA assigned to pass meds and 3 CNA's but if short in other areas of the facility, the staff CNA / CMA got pulled to the other areas and then they worked short on the area she was assigned. Staff may not be able to get residents up or baths not given. She also noticed some residents had weight loss due to residents not getting assistance with feeding. In an interview on 6/26/24 at 9:15 AM, Staff H, RN, reported the facility staff only 2 nurses for 60 residents, and sometimes only 1 nurse and a certified medication aide (CMA) to help pass medications. The facility staffed 5 CNA's but should have 6 CNA's. They tried to replace call ins but sometimes unable to replace staff. The other units are at minimal staffing so it's not an option to pull staff. Staff H acknowledged things didn't get done when they were short-staffed. She dealt with emergencies first and sometimes other things just didn't get done. Staff H reported she noticed delays in call lights getting answered, residents not getting repositioned timely, and residents not changed as frequently when not enough staff to care for all of the residents. A number of residents developed pressure ulcers. Staff H stated they did the best they could. In an interview on 6/26/24 at 9:40 AM, Staff I, CNA, reported they were supposed to have 6 CNA's on the [NAME] Halls but sometimes they only had 3 CNA's working which was not enough to take care of the residents and do everything they needed to do. Most of the residents on the [NAME] Hall required 2 staff for transfers. Staff I stated she either had to wait for someone to come help her transfer a resident or do things herself, or things don't get done. Staff I reported some residents needed help with feeding but there wasn't enough time to help people. The CNA's also gave the resident baths/showers in addition to the other CNA tasks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 6/26/24 at 3:20 PM, Staff J, RN, reported the [NAME] Hall had 60 residents. Normally, 6-7 CNA's needed to work on the [NAME] Unit Halls on the day and evening shifts, and 3 CNA's and a nurse on the night shift. Sometimes a staff person got pulled from the Central or NE Units to work on the [NAME] Unit when the [NAME] Unit was short staffed. Staff J reported he called the on-call person to find staff to come in. Sometimes they had to rearrange the residents shower day/time due to less staff. Call light response was a problem after supper. In an interview on 6/27/24 at 10:10 AM, the Human Resource (HR) Director reported she currently filled in as the scheduler until a new staff scheduler was hired and trained. The HR Director made the schedules for nurses, CNA's and dietary staff. The HR Director reported she used the On-Shift software program to create and modify staffs' schedule. A master schedule template had been set up by the Executive Director and Corporate based on their budget allotment for staffing. The HR Director explained they aimed to have the following numbers of staff/positions: On the day and evening shifts: West Hall: 6 CNA's, 2 nurses, 2 CMA's Central Hall: 3 CNA's, 1 nurse, 1 CMA NE Hall: 3 CNA's, 1 nurse On the night shift: West - 3 CNA's, 1 nurse Central 2 CNA's, 1 nurse, 1 CMA NE 2 CNA's, 1 nurse or CMA The HR Director reported staff entered a request to pick up available shifts through the On-shift program. The HR Director /scheduler checked On-shift program several times during the day and approved the shifts picked up by staff, then the person got added onto the schedule. She also made changes on the schedule whenever someone called in. In an interview on 6/27/24 at 11:50 AM, the Director of Nursing (DON) reported the bare minimum staffing would be at least four CNA's on the [NAME] halls, three CNA's on the Central (sklled unit), and two CNA's on the Northeast Hall. The DON reported it was harder when they worked with the minimum staffing level. She tried to cover staff whenever they had call-ins. The DON reported she no longer had the ability to approve shifts for staff to work. Staff are willing to work but upper management won't pay overtime. The DON stated residents admitted to the facility had multiple needs but don't always feel like they have the staff or resources to care for them. She was not included in the decision on which residents got admitted to the facility. The Admissions Coordinator and Executive Director determined who got admitted to the facility. The DON stated staff did their best to meet the needs of the residents. Staff not always able to get residents up, and they had a number of residents with pressure ulcers and skin issues. The DON stated she expected call lights answered within 15 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 6/27/24 at 2:15 PM, the Administrator reported the facility determined staffing needs based on PPD (hours per patient days) (The hours PPD is a measurement used to compare total number of direct nursing care hours (RNs, LPNs, and CNA's) to total number of patients served), utilizing the number of hours for nursing and CNA staff. They float between 3.6-4 ppd. They aim for a 1:15 ratio for staffing but staffing levels may be missed due to staff call ins. Nurse managers are on an on-call rotation and expected to come in and fill in when needed. The Administrator stated during peak times, it's all hands on deck to answer call lights, pass meal trays, and doing whatever is needed. Review of the Resident List Report dated 6/20/24 revealed 35 residents required assistance of one staff for transfers, 50 residents required assistance of two staff for transfers, and 31 residents considered independent with transfers. The report also revealed 81 of 116 residents required staff assistance for bed mobility. A facility policy titled Call lights: Accessibility and Timely Response implemented 8/10/22 revealed call lights directly relay to a staff member or centralized location to ensure appropriate response. Review of the Facility's Assessment revised 4/25/24 revealed the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. The assessment is used to make decisions about direct care staff needs, as well as capabilities to provide services to the residents at the facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The facility assessment revealed the facility organized into neighborhoods (units): [NAME] had 62 beds, Central had 58 beds, and Northeast had 30 beds. The staffing plan included the following: Licensed nurses: 3-5 each day and evening shift and 2-3 each night shift. A CMA may be used to supplement nurses if needed. Nurse Aides: 8-16 on day/evening shifts and 5-8 on night shift. This is the personnel needed to provide care, treatment, and services to the residents. From time to time the facility may have vacancies in various departments like any other business and that the facility then makes staffing adjustments that may include moving staff between departments, if appropriate, overtime, or agency assistance.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34817 Based on facility record review, policy review, and staff interview, the facility failed to have an effective quality assurance (QA) program in place to assist in the provision of quality care for residents and attain substantial compliance with Federal regulations and State rules. The facility identified a census of 116 residents. Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's annual survey 2/24/21 and 6/29/23, and complaint investigations completed 10/9/23, 2/27/24, and the current complaint investigations. The repeat deficiencies cited included: F725 cited 6/29/23, 10/9/23, and during the current survey F686 cited 2/24/21, 2/27/24, and during the current survey. A Quality Assurance and Performance Improvement (QAPI)) change process implemented 10/24/22 revealed the QAPI as a systematic approach for performance improvement activities to ensure changes are effective and improvements are sustained. Performance improvement is a continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying opportunities for improvement, testing new approaches to fix underlying causes of persistent and systemic problems or barriers to improvement. The QAPI focused on systems and processes, identified system gaps, and identified root causes of concern. In an interview on 6/27/24 at 2:15 PM, the surveyor asked the Administrator what the facility had done to improve and address the repeat deficiencies from the most recert survey and prior surveys. The Administrator responded he had been the Administrator at this facility since 3/2024, and he couldn't speak for prior Administration. They continued to do audits and staff education monthly since he started in 3/2024. The Administrator stated he looked at the CASPER report and the areas that affected the facility's 5-Star Rating Scale and chose to work on pressure ulcers due to pressure ulcers had a higher rating. He implemented a PIP (Performance Improvement Plan) on 4/2024, and put in some action plans in the past month. An all staff skills fair held 6/5 -6/7/24 which entailed skin observations, assessments, and other areas of concern. They made a targeted effort and are strategically working with staff to be successful to learn what needs to be done. For staffing and call light response times, they aimed for a 1:15 ratio for staffing but the staffing levels may be missed due to the staff call ins. Nurse managers are on an on-call rotation and expected to come in and fill in when needed. During peak times, it's all hands on deck helping to answer call lights, pass meal trays, and do what is needed.