

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Blackhawk Life Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 73 West 5th Street Lake View, IA 51450	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on interviews, record and policy review, the facility failed to investigate new bruising on a resident for 1 of 4 residents reviewed for accidents, (Resident #25). On 10/1/24 staff discovered bruising on Resident #25, the administration indicated that the bruising was explained by an incident with the EZ stand mechanical lift that happened on 9/7/24. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated [DATE], Resident #25 was admitted to the facility on [DATE] and had a BIMS score of 4 (severe cognitive deficit). The resident required partial/moderate assistance with sit to stand, chair to bed transfers and toilet transfers. Resident #25 was frequently incontinent of urine and bowel and she had physical and verbal behavior directed toward others 4-6 days a week. Her diagnosis included diabetes mellitus, Alzheimer's disease, anxiety disorder.</p> <p>The Care Plan revised on 9/12/24, showed Resident #25 had impaired function and required the assistance of 2 staff with walking, and toileting. Staff used the EZ Stand (mechanical lift) at times if unable to complete tasks. The resident had impaired cognitive function with a history of yelling, wandering, swearing at staff. She was at risk for skin breakdown, staff were to observe skin for abnormal signs of bruising due to use of antiplatelet medication.</p> <p>An Incident Report dated 10/1/24 at 2:20 PM, showed that Resident #25 was found to have purple bruising on the left side of her rib cage that measured 6.0 centimeters (cm) x 3.0 cm. Another bruise was found on her left hand that measured 7.4 cm x 5.3 cm. The resident was unaware of bruising.</p> <p>On 10/23/24 at 1:59 PM, when asked about an investigation on the source of the bruising, the Administrator said she thought it was related to an incident where Resident #25 had a near miss on the EZ stand and she became unhooked from the lift which may have caused the bruising.</p> <p>On 10/24/24, Staff E, Assistant Director of Nurse (ADON), presented hand written notes dated 9/9/24 that showed on 9/7/24 Resident #25 had a near miss fall using the EZ stand. The resident had been agitated and stomping her feet, and shaking the machine. At some point the loop unhooked, the resident swung to the left, and Staff D caught her to prevent her from falling to the floor.</p> <p>The chart lacked a nursing assessment after the incident.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Weekly Skin Integrity Assessments dated 9/10 and 9/17 showed that there were no new skin issues.</p> <p>On 10/24/24 at 10:32 AM, Staff I, CNA stated that she had first noticed the bruising on Resident #25 on 10/1/24 and she reported it to Staff G, RN. She said she did all of baths for resident #25 in Sept and did not see any marks before this date.</p> <p>A review of the Shower/Bath documentation showed that on 9/10, 13, 17, and 24, Staff I completed the showers for Resident #25 and reported no new skin issues.</p> <p>On 10/25/24 at 12:02 PM, the Administrator, Director of Nursing (DON) and Staff E, Registered Nurse (RN) all agreed that the timing for a bruise to appear after an injury, depended on the individual and that it was reasonable to conclude that the bruising that first appeared on 10/1/24 could have been caused by the EZ stand incident on 9/7/24. They stated that they did some staff interviews when the bruising was found but did not have documentation of the interviews and they did not do further investigation of the possible causes. They said that when they came into work on 9/9/24, they did as assessment of the resident and there were no injuries noted. They would have expected that the nurse would have done an assessment that evening.</p> <p>According to Medical News Today; What Do the Colors of Bruising Mean? Retrieved on 10/28/24 from: https://www.medicalnewstoday.com/articles/322742#bruise-colors</p> <p>Within 24 hours of an injury a bruise often turned red. After 1-2 days the bruise that was a few days old would often appear blue, purple, black or slightly darker than surrounding skin. After 5-10 days the bruise may turn yellow or green, and after 10-14 days the bruise may turn yellowing-brown or light brown. The bruise would disappear within 2 weeks.</p> <p>According to a facility policy titled: Accidents, Incidents, Investigation and Reporting. Reviewed 4/22/24, All accidents or incidents involving a resident .shall be investigated. The nursing supervisor .shall promptly initiate and document an investigation of the accident or incident. The Director of Nursing would ensure that the incident report was completed.</p> <p>According to the Abuse Prevention; Incidents, Investigations, Reporting, revised on 9/9/24, examples of injuries that could indicate abuse include; bruises, including those found in unusual locations, head, neck arms torso and trunk.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observation, interview and record review the facility failed to ensure that staff assessed residents after incident for 1 of 4 residents reviewed, (Resident #25). Resident #25 slid from the EZ Stand mechanical lift when the sling hook disengaged. The chart lacked a nursing assessment. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated [DATE], Resident #25 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 4 (severe cognitive deficit). The resident required partial/moderate assistance with sit to stand, chair to bed transfers and toilet transfers. Resident #25 was frequently incontinent of urine and bowel and she had physical and verbal behavior directed toward others 4-6 days a week. Her diagnosis included; diabetes mellitus, Alzheimer's disease, anxiety disorder.</p> <p>The Care Plan revised on 9/12/24, showed Resident #25 had impaired function and required the assistance of 2 staff with walking, and toileting. Staff could use the EZ Stand (mechanical lift) at times if unable to complete tasks. The resident had impaired cognitive function with a history of yelling, wandering, and swearing at staff. She was at risk for skin breakdown, staff were directed to observe her skin for abnormal signs of bruising due to the use of antiplatelet medication.</p> <p>On 10/23/24 at 1:59 PM, the Administrator said Resident #25 had a near miss on the EZ stand when the sling unhooked from the lift during transfer. She did not know if there was an incident report.</p> <p>On 10/24/24, Staff E, Assistant Director of Nurse (ADON), presented hand written notes dated 9/9/24 that showed on 9/7/24 Resident #25 had a near miss fall using the EZ stand. The resident had been agitated and stomping her feet, and shaking the machine. At some point the loop unhooked, the resident swung to the left, Staff D caught her and held onto her until Staff K could get the WC under the resident. Immediate action to double check all hook ups, loops and belt. A statement from Staff K showed that the charge nurse had been told immediately after the incident and the CNA's were told that since it wasn't a fall, they did not need to fill out an incident report. The intervention was to include a Time Out period after a resident was up on the EZ stand and check belt and hooks before proceeding with transfer.</p> <p>A review of the Nursing Notes for Resident #25 revealed that on the overnight shift of 9/7 - 9/8 the only progress notes entered, included references to the resident hollering at staff, and that she made no attempts to exit the building. The chart lacked reference to incident on the EZ Stand transfer.</p> <p>The Standard Assessments tab in the electronic chart lacked any assessments on 9/7/24 or 9/8/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/24/24 at 10:05 AM, Staff D, CNA said that on the evening of 9/7/24, Resident #25 was having a rough night with lots of hitting, kicking and screaming. Staff D and Staff K decided to use the EZ stand to transfer the resident to the toilet because the resident wasn't standing very well. Resident #25 had been incontinent of bowel, and Staff D was cleaning the resident from behind, while Staff K pulled the EZ stand from the bathroom to the bed room. The resident became increasingly angry and yelled that's enough. The staff tried to explain that they needed to get her cleaned and the resident stomped her feet, and shook back and forth on the machine while holding onto side of machine. As she was rocking the machine, one of the slide loops came undone and the resident slid to the side. Staff D grabbed onto the resident and held her so she would not fall, while Staff K got the wheel chair and slid it under her. The CNA's reported the incident to the nurse on duty and were told that because she didn't hit the floor they didn't need to do an incident report. Staff D did end up filling out an employee incident report because she hurt her back when she held onto the resident.</p> <p>On 10/24/24 at 9:46 AM, Staff L, RN, said that she knew the CNA's were having issues with the Resident #25 on the evening of 9/7/24. She tried to recall if there were any incidences reported to her she thought that when they went to lower the resident into the chair she sat down hard She denied knowing anything about the sling coming unhooked but she remembered that Staff D had hurt her back. Staff L denied any knowledge of the EZ stand sling coming unhooked. She said that she did not do an assessment or fill out an incident report because the resident came out to the dining room later and she was okay.</p> <p>On 10/25/24 at 12:02 PM, the Administrator, and Director of Nursing (DON) said that they would have expected that the nurse to complete a full assessment of the resident after the accident. They would also expect that the nurse would have completed an incident report at that time and were not sure why she hadn't.</p> <p>The facility policy titled: Nurse Assessment; Accident and Change in Condition showed that when an accident or change condition occurred, nursing will place resident on hot chart to identify follow up needs. Nursing staff would monitor and document in the resident's progress.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observation, interview and record review the facility failed to safely transfer residents with the mechanical lifts for 2 of 4 residents reviewed (Resident #10 and #25). Resident #25 slid from the EZ Stand mechanical lift when the loop on the sling disengaged. Resident #10 sustained bruising when she was hit in the head with the arm of the Hoyer mechanical lift during transfer. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) dated [DATE], Resident #10 had a Brief Interview for Mental Status (BIMS) score of 99 (unable to participate). She was totally dependent on staff for her hygiene needs, dressing, toileting, transferring and for rolling in bed.</p> <p>The Care Plan for Resident #10, dated 9/20/24, showed she had severe cognitive impaired function and impaired communication due to Alzheimer's disease. The resident was non-ambulatory, nonverbal, and required the use of a Hoyer mechanical lift with the assistance of two staff. She had a terminal prognosis, was on hospice services and her diagnosis included; type 2 diabetes mellitus, heart disease, chronic kidney disease and Alzheimer's Disease.</p> <p>On 10/21/24 at 12:30 PM, Resident #10 was in her wheel chair getting assistance with lunch. She had yellow bruising on the right side of her face.</p> <p>An Incident Report dated 10/10/24 at 3:30 PM, showed that after transfer, the top bar of the Hoyer lift had swung over and bumped Resident #10 on the side of her head and caused a hematoma 4 centimeters (cm) x 4.5 cm. with purple bruise in the center. The Hoyer lift leg had gotten stuck under the wheel chair and when staff pulled the machine back, the sling bar hit the resident.</p> <p>On 10/21/24 at 12:36 PM, Staff B, Certified Nurse Aide (CNA) said that she was present when the Hoyer arm hit the resident on the side of her head. She said that the wheel chair was sitting sideways, and straddled the left leg of the Hoyer. They lowered the resident to the chair, unhooked the sling, and when Staff D, CNA went to pull the Hoyer out from under the wheel chair, it got stuck. As Staff D pulled back, the arm with the 6 latches (where the sling was hooked) swung back and hit the resident on the head.</p> <p>On 10/23/24 at 9:06 AM, Staff D said that when the arm hit Resident #10, she was guiding the Hoyer, and Staff B was guiding the chair. She said that she placed the wheel chair sideways because the resident was so tall it worked better to lower her safely in the chair from that direction. She said that when she went to move the Hoyer back, she had asked Staff B to hold onto the arm so it wouldn't swing, but Staff B did not help stabilize it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. According to the MDS dated [DATE], Resident #25 was admitted to the facility on [DATE] and had a BIMS score of 4 (severe cognitive deficit). The resident required partial/moderate assistance with sit to stand, chair to bed transfers and toilet transfers. Resident #25 was frequently incontinent of urine and bowel and she had physical and verbal behavior directed toward others 4-6 days a week. Her diagnosis included diabetes mellitus, Alzheimer's disease, anxiety disorder.</p> <p>The Care Plan revised on 9/12/24, showed Resident #25 had impaired function and required the assistance of 2 staff with walking, and toileting. Staff could use the EZ Stand if they were unable to complete tasks. The resident had impaired cognitive function with behaviors, had a history of yelling, wandering, and swearing at staff. She was at risk for skin breakdown, staff were to observe skin for abnormal signs of bruising due to use of antiplatelet.</p> <p>On 10/23/24 at 1:59 PM, the Administrator mentioned that Resident #25 had a near miss on the EZ stand and she became unhooked from the lift.</p> <p>A review of the Incident Reports for Resident #25 from May - October revealed there was no report for an EZ stand accident.</p> <p>Staff E, Assistant Director of Nurse (ADON), presented hand written notes dated 9/9/24 that showed on 9/7/24 Resident #25 had a near miss fall using the EZ stand. The resident had been agitated and stomping her feet, and shaking the machine. At some point the loop unhooked, the resident swung to the left, Staff D caught her and held onto her until Staff K could get the WC under the resident. Immediate action to double check all hook ups, loops and belt. A statement from Staff K showed that the charge nurse had been told immediately after the incident and the CNA's were told that since it wasn't a fall, they did not need to fill out an incident report. The intervention was to include a Time Out period after a resident was up on the EZ stand and check belt and hooks before proceeding with transfer.</p> <p>On 10/24/24 at 10:05 AM, Staff D, CNA said that on the evening of 9/7/24, Resident #25 was having a rough night with lots of hitting, kicking and screaming. Staff D and Staff K decided to use the EZ stand to transfer the resident to the toilet because the resident wasn't standing very well. Resident #25 had been incontinent of bowel, and Staff D was cleaning the resident from behind, while Staff K pulled the EZ stand from the bathroom to the bed room. The resident became increasingly angry and yelled that's enough. The staff tried to explain that they needed to get her cleaned and the resident stomped her feet, and shook back and forth on the machine while holding onto side of machine. As she was rocking the machine, one of the slide loops came undone and the resident slid to the side. Staff D grabbed onto the resident and held her so she would not fall, while Staff K got the wheel chair and slid it under her. The CNA's reported the incident to the nurse on duty and were told that because she didn't hit the floor they didn't need to do an incident report. Staff D did end up filling out an employee incident report because she hurt her back when she held onto the resident.</p> <p>On 10/24/24 at 10:59 AM, Staff K said that they used the EZ stand on 9/7/24 because Resident #25 was very unstable and agitated. She said that they were trying to clean up because she had bowel movement (BM) all down her back. The resident became increasingly upset and started bouncing up and down and having a tantrum. The right side strap came off of the lift and then Staff D supported the resident while Staff K, got the wheel chair under her. Staff K said that they told the nurse right away but she did not know if there was an assessment or documentation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/24/24 at 9:46 AM, Staff L, RN, said that she knew the CNA's were having issues with the Resident #25 on 9/7/24. She tried to recall if there were any incidences reported to her she thought that when they went to lower the resident into the chair she sat down hard She denied knowing anything about the sling coming unhooked but she remembered that Staff D had hurt her back. Staff L denied any knowledge of the EZ stand sling coming unhooked. She said that she did not do an assessment or fill out an incident report because the resident came out to the dining room later and she was okay.</p> <p>On 10/25/24 at 12:02 PM, the Administrator, Director of Nursing, and Staff E, RN said that since the incident, they had established a checklist for the operation of the EZ stand and taught staff to stop and double check that all the straps were secured and the belt was tightened before transferring a resident. They said that they did a skin assessment on 9/9/24 and there were no injuries noted.</p> <p>According to the facility policy titled EZ Stand (Sit to Stand) revised on 10/3/24. Staff were to adjust the belt for tight fit, once the resident was in standing position on the lift, double check that the strap was flush against the attachment knob.</p> <p>According to the undated facility policy titled; Hazardous Area/ Devices and Equipment, data from accident and incident reports would be used as part of the hazard's assessment and analysis, including trends in accident types, areas in the facility, associations with particular staff or shifts and equipment use. Resident specific interventions would include changes to the plan of care and/or increased supervision.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41785</p> <p>Based on observation, interview and policy review the facility failed to ensure that dietary staff performed proper glove use while serving meals. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>In an observation of the lunch service on 10/22/24, at 11:06 AM, Staff H, Dietary Aide (DA) had disposable gloves on and he touched many surfaces such as the counter, carts and utensils. He then grabbed a bread bag, reached into the bag and pulled out 6 pieces of bread with same gloves. He then buttered the bread, put it on a plate and covered it with wrap. Staff H then disposed off the gloves.</p> <p>On 10/22/24 at 1:30 PM, the Dietary Manager (DM) said that she taught kitchen staff to use gloves only when they would be handling food directly. She said that glove use was a challenge when staff feel like they can touch any surface with them on and then touch food.</p> <p>According to the undated facility policy titled: Gove Use Policy; if staff used gloves they must still follow hand washing guidelines, change gloves and wash hands between possible contaminations and before starting a new task.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on interviews, record and policy review the facility failed to complete accurate and timely records for 1 of 12 residents reviewed, (Resident #25). Resident #25 slid from the EZ Stand mechanical lift when the loop came off. Staff failed to fill out an incident report and failed to document the incident in the nursing notes. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>According to the MDS dated [DATE], Resident #25 was admitted to the facility on [DATE] and had a BIMS score of 4 (severe cognitive deficit). The resident required partial/moderate assistance with sit to stand, chair to bed transfers and toilet transfers. Resident #25 was frequently incontinent of urine and bowel and she had physical and verbal behavior directed toward others 4-6 days a week. Her diagnosis included diabetes mellitus, Alzheimer's disease, anxiety disorder.</p> <p>The Care Plan revised on 9/12/24, showed Resident #25 had impaired function and required the assistance of 2 staff with walking, and toileting. Staff used the EZ Stand (mechanical lift) at times if unable to complete tasks. She had impaired cognitive function behavior, had a history of yelling, wandering, and swearing at staff. She was at risk for skin breakdown, staff were directed to observe skin for abnormal signs of bruising due to use of antiplatelet medication.</p> <p>On 10/23/24 at 1:59 PM, the Administrator said that Resident #25 had a near miss on the EZ stand. She did not know if there was an incident report completed for the accident.</p> <p>A review of the incident reports for Resident #25 from May - October revealed there was no report for EZ stand accident.</p> <p>A hand written note dated 9/9/24 from Staff E, Assistant Director of Nurse (ADON), showed that on 9/7/24 Resident #25 had a near miss fall when the loop on the sling unhooked from the EZ Stand mechanical lift during transfer. The resident swung to the left, and Staff D, Certified Nurse Aide (CNA) caught her and held onto her until Staff K got the wheel chair under the resident. Staff D injured her back when she caught and held the resident. Staff K indicated that they told the charge nurse immediately and the response was that since it wasn't a fall, they did not need to fill out an incident report.</p> <p>The Nursing Notes for the overnight shift of 9/7 - 9/8, included references to the resident hollering at staff and that she made no attempts to exit the building. The chart lacked reference to an incident on the EZ Stand transfer.</p> <p>On 10/24/24 at 9:46 AM, Staff L, Registered Nurse (RN), said that she knew the CNA's were having issues with Resident #25 on 9/7/24, but she denied knowing anything about the sling coming unhooked from the EZ Stand. She said that Staff D hurt her back during an incident. Staff L said that she did not do an assessment or fill out any incident report that evening. The resident came out to the dining room later and she was okay.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Standard Assessments tab in the electronic chart lacked any assessments for 9/7/24.</p> <p>On 10/25/24 at 12:02 PM the Administrator and the Director of Nursing (DON) said that they did an assessment on Resident #25 on 9/9/24 and there were no injuries noted. They would have expected that the nurse would have done an assessment the evening of the incident but were not sure that she knew about the incident. They would also expect that the nurse would have completed an incident report and a nursing progress note.</p> <p>According to a facility policy titled: Accidents, Incidents, Investigation and Reporting, reviewed 4/22/24, All accidents or incidents involving a resident .shall be investigated. The nursing supervisor .shall promptly initiate and document an investigation of the accident or incident. The Director of Nursing would ensure that the incident report was completed.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Blackhawk Life Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 73 West 5th Street Lake View, IA 51450	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527</p> <p>Based on observation, record review and staff interview, the facility failed to ensure staff practiced appropriate infection control practices for 1 of 12 residents reviewed (Resident #8). The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #8 scored 9 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident was dependent on staff for lower body dressing and undressing. The resident had diagnoses including chronic heart failure, and swelling of the bilateral lower legs.</p> <p>The current Care Plan identified the resident at risk for altered skin integrity related to obesity, incontinent episodes of bowel and bladder, a history of moisture associated skin damage (MASD) and use of diuretics for edema & congestive heart failure (CHF). The resident moved minimally and her norm. She required assistance with self care and mobility tasks. Her motivation was poor which placed her at risk for skin breakdown. She suffered from dependent edema to her legs and needed assist with getting/keeping her legs elevated. The interventions included:</p> <p>a. 10/11/24 Skin Tear to right lower leg. 10/22/24 cellulitis with antibiotic started.</p> <p>b. 10/11/24 treatment to right lower leg daily until healed. Observe effectiveness and report signs of infection.</p> <p>Updated 10/19/24: antibiotic treatment started for cellulitis to right lower extremity.</p> <p>c. Administer antibiotic for cellulitis to right lower leg as ordered. Observe effectiveness of use and for adverse side effects. Report worsening signs of cellulitis to or surrounding 10/22/2024.</p> <p>e. Perform skin assessment as ordered, per skin integrity flow sheet. Report changes to skin integrity if indicated.</p> <p>The Progress Notes dated 10/11/24 at 11:04 p.m. documented staff reported to the nurse that during transfer with the resident, a skin tear occurred on the outer lower right leg. The resident had a 3 by 2 cm crescent shaped skin tear. The edges were well approximated, and the area weeped serosanguinous drainage. A non adherent dressing applied and covered with gauze.</p> <p>The Progress Notes dated 10/12/24 at 10:55 a.m. documented clear weeping noted to the resident's right lower leg. The dressing was saturated along with a bed pad placed under the area. The open area was deep purple in color. No pain noted with the dressing change.</p> <p>The Physician's Order included cleansing the right lower leg with wound cleanser, covering with an oil emulsion dressing, non adherent telfa, and securing with Medipore tape. The dressing changed daily until dry, then leave open to air, one time a day for skin tear/weeping dated 10/12/24.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Blackhawk Life Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 73 West 5th Street Lake View, IA 51450	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Notes dated 10/19/24 at 1:37 p.m. documented the resident had a cellulitis wound to her right lower leg, with copious amount of serous drainage noted. The wound measured 1.8 cm x 1.5 cm. An oil emulsion dressing applied, covered with 2 abdominal (ABD) pads, wrapped with kling and secured with Medipore tape. The resident had no complaints of pain with the leg.</p> <p>The Physician's Orders included Keflex 500 mg by mouth three times a day for cellulitis to the resident's right lower leg for 10 days</p> <p>The Progress Notes dated 10/23/24 at 8:29 a.m. documented the resident remained on antibiotic for cellulitis of the right lower leg with no adverse effects noted. Performed daily dressing change per orders. The old dressing removed and both ABD pads saturated with clear drainage, et the bed pad under the leg wet. The right lower leg appeared light red in color, warm to the touch, and painful to touch. The resident verbalized pain at 9/10 when touched or lifted her leg up. The resident grimaced et moaned out during the dressing change.</p> <p>During an observation on 10/22/24 at 10:12 AM Staff A Registered Nurse (RN) went to do the resident's treatment. Staff A placed the treatment supplies on the resident's tray table without a barrier (dressings, tape). Resident #8 had a rectangle dressing on her right anterior lower leg with plastic wrap around the right leg and partially around the dressing. A black wound to the more lateral right lower leg was draining and uncovered. Staff A put gloves on and then removed them to leave the room. She returned and without performing hand hygiene, put on the pair of gloves she removed before putting on a second pair of gloves over them. Staff A removed the dressing and had to tear the plastic wrap away from around the resident's right leg. She removed the top gloves and threw them and the dressing away. A bunched up dressing laid on the floor near the bed. She applied an oil emulsion dressing to the dark area after measuring at 1.8 by 1.3 cm. She covered the dark lateral wound with telpha, ABD's and gauze wrap to keep in place, and taped. The resident's slipper was wet from clear drainage from the resident's wound per Staff A. Staff A removed gloves and washed her hands, then left the room with the tape, and without changing the resident's slippers. The dressing near the bed remained on the floor.</p> <p>On 10/23/24 at 3:16 p.m. the Director of Nursing (DON) stated she didn't know about double gloving. She said when your gloves were soiled you changed gloves and washed your hands. She said wound supplies should be placed on a barrier in a resident's room. Any dressing on the floor should be picked up and disposed of immediately. The slippers should have been changed right away</p> <p>The facility Handwashing and Glove Use policy revised 9/9/20 directed using an alcohol based hand rub after handling used dressings, contaminated equipment, etc . after removing gloves.</p> <p>Applying and removing gloves included performing hand hygiene before applying non-sterile gloves.</p>		