STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165504	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Algona Manor Care Center	2221 East McGregor Street Algona, IA 50511

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to revise a Care Plan for 1 of 13 residents reviewed (Resident #21) for prophylactic antibiotic therapy. The facility reported a census of 35. Findings include: Resident #21 ' s Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #21 ' s MDS included diagnoses of coronary artery disease, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD) and pulmonary embolism (blood clot in lungs) without acute cor pulmonale. The Care Plan with revised date of 7/24/24 identified Resident #21 required assistance with activity of daily living due to COPD. The Care Plan revealed Resident #21 had supplemental oxygen continuously. The Care Plan directed staff to update the Physician with any signs of respiratory distress such as a decreased oxygen saturation and complaints of new onset of shortness of breath. A Physician Order dated 5/15/24 directed staff to administer azithromycin (antibiotic) 250 mg (milligrams) one tablet every Monday, Wednesday and Friday related to COPD. A Pharmacy Consulting form dated 6/19/24 documented a physician order to continue the azithromycin 250 mg on Monday, Wednesday and Friday for 365 days due to COPD exacerbation, pneumonia and rehospitalization . Review of Resident #21 ' s Care Plan revealed the antibiotic medication, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan. On 8/6/24 at 11:28 AM, the Director of Nursing (DON) acknowledged and verified the antibiotic was not on the care plan. The DON reported she would expect the antibiotic to be addressed on the care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy titled Care Plan Development documented the facility will develop a comprehensive plan of care to include approaches, goals, and interventions that reflect the resident ' s preferences and choices. The policy further documented the plan of care will be reviewed periodically for the need for updating, modifying, or additions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review and staff interviews, the facility failed to provide assessment and interventions necessary for the care and services, to maintain the residents' highest practical physical well-being for 1 of 3 resident reviewed (Resident #13) for antibiotic therapy. The facility failed to monitor and complete urinary assessments/interventions for a resident who was diagnosed with a urinary tract infection. The facility reported a census of 35 residents. Findings include: Resident #13 ' s Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 04, indicating severely impaired cognition. The MDS identified Resident #13 was dependent on staff for toilet transfers and toileting hygiene. The MDS documented Resident #13 was frequently incontinent of urine. Resident #13 ' s MDS included diagnoses of coronary artery disease, hypertension (high blood pressure), urinary tract infection (UTI) in the past 30 days, and non-alzheimer ' s disease. The facility infection control logs from January 2024 to July 2024 revealed Resident #13 had been treated for a UTI with antibiotics on the following dates: -1/5 to 1/8 -1/16 to 1/23 -2/14 to 2/21 -5/1 to 5/8 -7/9 to 7/16 Review of the current Care Plan with target date 10/14/24 did not address Resident #13 was at risk for urinary tract infections, what signs and symptoms to monitor for and interventions to reduce the risk for UTI. The Care Plan revealed Resident #13 was incontinent of urine, was not always able to voice the urge to void and had a history of nocturia. The Care Plan directed staff to assist with toileting 2-3 times each night. A Progress Note dated 7/8/24 at 1:32 PM documented Resident #13 had been looking up to her right towards the ceiling, she thought she saw a blue car and that her son was picking her up. The note documented Resident #13 required more assistance at meals and was not aware she was going to spill her coffee. The note revealed Resident #13 has increased frequency and increased bladder incontinence. Resident #13 ' s urine was odorous and cloudy in appearance. A urine dip test was completed and results were positive for leukocytes, nitrates, protein and specific gravity was 1.010. A message was left at the Provider ' s office regarding Resident #13 ' s symptoms and urine dip results. The Progress Note lack documentation of a completed set of vitals signs (temperature, pulse, respirations, blood pressure) related to Resident #21 ' s change in condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 7/9/24 at 1:42 PM documented a new order was received to obtain a clean catch urinalysis. A Progress Note dated 7/9/24 at 4:31 PM documented Resident #13 had a UTI and a culture was indicated. A new Physician Order was obtained to start Keflex (antibiotic/ATB) 500 mg (milligrams) TID (three times a day) for 7 days. Review of the July 2024 Medication Administration Record (MAR) revealed Resident #13 started Keflex on the evening of 7/9/24 for a UTI. A hospital microbiology report dated 7/10/24 at 7:16 PM revealed the urine culture grew out, greater than 100,000 cfu/ml (colony-forming unit per millilitre) escherichia coli (gram negative bacteria commonly found in lower intestine). Review of the Progress Notes from 7/9/24 to 7/16/24 lacked urinary assessments, monitoring of routine vital signs and documentation of any adverse drug effects while taking the antibiotic. Review of the July MAR revealed Resident #13 completed the Keflex at Noon on 7/16/24. The Progress Notes lacked documentation Resident #13 had completed antibiotic therapy. The documentation also lacked a full set of vitals signs and whether or not the ATB therapy was effective. On 8/7/24 at 4:00 PM, the Director of Nursing (DON) reported the first three days a resident was on an antibiotic for a UTI, she would expect the staff to document full set of vitals signs along with urinary symptoms, signs/symptoms of infection and any adverse drug reactions from the antibiotic therapy. She stated on the last day of the antibiotic she would expect full set of vitals signs and documentation if there was any improvement or not from the antibiotic therapy. The DON reported she could not locate any facility policies on what to document or monitor for when a resident was on an antibiotic.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49056 Based on observations, record review, staff interviews and facility policy the facility failed to properly prevent a stage 1 pressure ulcer consistent with professional standards of practice for 1 of 2 residents reviewed (Resident #26). The facility reported a census of 35 residents. 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. 1. The Minimum Data Set (MDS) assessment tool dated 5/7/24, for Resident #26 documented diagnoses that included malnutrition, diabetes mellitus, Non-Alzheimer ' s dementia, parkinson ' s disease, anxiety and depression. The MDS showed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS identified the resident as at risk for pressure ulcers. The MDS also identified the facility had placed a pressure reducing cushion in the resident ' s chair and pressure reducing device for the bed. Resident #26 ' s Care Plan revised on 5/10/24 contained the following information: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26 is at risk for altered skin integrity and pressure related injury related to decreased mobility, age, diagnosis of type 2 diabetes, dementia, decreased meal intake and diagnosis of Parkinsons. The Care Plan directed staff to offer and encourage Resident #26 to utilize heel protectors, Resident #26 does refuse to allow staff to have these placed on her feet. To utilize a pressure relieving cushion in her wheelchair and pressure relieving mattress on bed. Nursing will complete a skin assessment each week to monitor for areas of concern updating the physician as needed. Please notify my charge nurse of any redness, new discoloration or concerns to my skin noted during care. Administer medications as ordered, monitor and document as needed for side effects and effectiveness Staff to apply moisture barrier cream with incontinent care. Staff to encourage me to lay down in the afternoon for pressure relief, at times I refuse and prefer to stay sitting in my recliner. Staff will assist with floating my heels while I am in bed to decrease my risk for injury or further injury to my heels while I am in bed. Staff will assist with re-positioning in bed every 2-3 hours for pressure relief. The resident's Care Plan lacked any new information related to the stage 1 pressure on the resident's left heel and any new interventions the facility put in place. The facility provided Braden Scale dated 8/1/24 showed Resident #26 scored a 12 which indicated a high risk for pressure ulcers. The facility provided Braden Scale dated 5/7/24 showed Resident #26 scored a 12 which indicated a high risk for pressure ulcers. The facility provided Braden Scale dated 2/6/24 showed Resident #26 scored a 15 which indicated risk for pressure ulcers. The Pressure Ulcer Documentation revealed the following information: the treatment is to apply a foam pad two times a week on shower days and as needed. The physician signed the Pressure Ulcer Documentation sheet on 7/19/24. The following are the measurements: 7/17/24 Left heel - is 2 centimeters (cm) x 1 cm (length x width) - area with brown discoloration (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/23/24 Left heel - 3 cm x 1.2 cm - area with brown discoloration 7/30/24 Left heel - 2.2 cm x 0.6 cm - area with intact brownish discoloration 8/6/24 Left heel - 2 cm x 0.4 cm - area with light brown discoloration 8/6/24 Right buttock - 0.3 cm x 0.2 cm x 0.1 cm - area with pink edges and wound bed is red 8/6/24 Coccyx - 1.5 cm x 0.3 cm x 1 cm - area is light red with pink edges The Treatment Administration Record (TAR) for July 2024 failed to reveal an order for a treatment to the left heel was being completed. The TAR for August 2024 failed to reveal an order for a treatment to the left heel was being completed. Review of Resident #10 ' s Progress Notes revealed the following: On 7/16/24 at 10:16 AM, During skin check today new pressure to left heel, Stage 1. On 7/19/24 at 2:18 PM, Received signed skin sheet regarding area to patient right heel. On 2/12/24 at 6:20 PM, Previous pressure ulcer on right heel resolved on 12/20/23. Preventative pressure relieving mattress on bed, cushion used when up on chair and purple booties on feet (except for transferring). Resident #26 has a history of pressure ulcers to her heels per Progress Notes dated 2/12/24. Observation on 8/7/24 at 1:19 PM with Resident #26 sitting in a recliner at this time with feet up. Resident #26 observed not sitting on a cushion or pressure reducing device. Resident #26 has slipper socks on and bilateral heels are not touching anything, heels are off the foot of the recliner. Observation on 8/7/24 at 3:17 PM with the DON. The DON went into Resident #26 ' s room, Resident #26 was sitting in a recliner with feet up with gripper socks to bilateral feet. DON pulled off the gripper sock to left foot, observed a white bandage on the heel, the DON then removed this bandage. The bandage failed to have a date of when it was applied. Observed left heel with brown discolored area, skin was intact. DON encouraged Resident #26 to wear heel boots and Resident #26 agreed at this time. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility provided policy named Skin Assessment, Impaired Skin Integrity, Wound Care with an effective date of 12/5/16 revealed the goal of the skin assessment and reassessment is to maintain the resident at their highest practical physical well-being, early identification, implementation of interventions, registered nurse (RN) evaluation of effectiveness of interventions and timely revision of the resident care plan. Assessments are completed by an RN or licensed practical nurse (LPN), with evaluation of changes in assessment and review/revision of resident care plan by an RN. All staff are accountable for documenting interventions they complete. The RN is accountable for evaluating effectiveness of interventions and care. Notification of the resident, physician/nurse practitioner, family or representative will occur, upon discovery of a pressure ulcer, wound status is declining or shows no progress in one to two weeks. Interview on 8/7/24 at 3:17 PM with the DON, she acknowledged that the treatment was not put on the treatment sheet. The DON stated that the treatment is a standing order and the process would be for the nurse to put the order in the computer so it would be generated to the treatment sheet. DON acknowledged this should have been done when the area was found. Interview on 8/8/24 at 12:50 PM with the DON revealed there is no documentation when Resident #26 would refuse to wear the heel boots, the staff reported it to the nurses. The DON reported that there was not another intervention in place before the pressure ulcer to the left heel was found.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46875 Based on observations, staff interviews and policy review, the facility failed to store food items according to professional standards and ensure food items were labeled with dates after opening. The facility identified a census of 35 residents. Findings include: 1. An initial kitchen tour conducted on 8/5/24 at 10:05 AM, of the kitchen revealed the following items were stored/opened in the kitchen's refrigerator ready for service and not labeled with a date after opening: a. American cheese slices in zip lock bag b. Container of ham salad c. Slices of smoked ham in zip lock bag d. Individual packed slices of Swiss cheese e. 46 oz Tomato juice f. 16 oz butter blend spread block- not sealed appropriately g. Cookies Mild salsa h. 1 gallon worcestershire sauce i. Heinz tomato ketchup j. 1 gallon tartar sauce k. 30 oz Mayonnaise l. 24 oz Hershey syrup m. 12 oz Dijon Mustard n. 12 oz honey mustard o. 1 gallon chocolate milk p. Two 1 gallon 2% milk q. Pint Half & Half cream and milk (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	r. Half gallon Almond breeze s. Heavy whipping cream t. 7 servings cucumber salad in individual bowls u. Bag of hot dogs opened and dated 7/27/24. 2. The following items were stored/opened in the kitchen's freezer and not labeled with date after opening: a. Bag of frozen fish sticks- The bag was not sealed and freezer burn noted. b. Bag of frozen omelets c. Bag of frozen of chicken strips. 3. The following items were stored in the kitchen's dry storage area: a. Instant banana pudding mix- open, not dated b. 2nd bag of instant banana pudding mix- open, not sealed, dated 3/20/24 c. Dry gelatin mix- open, not dated d. Chocolate pudding mixture- open and dated 10/19/23 e. Raisin Bran cereal- open, not sealed, not dated. On 8/5/24 at 10:30 AM, The Dietary Manager reported he expected the dietary staff to label and date items when opened and left over food was good for 7 days after opening. The undated facility policy titled Dietary Services documented once the product was opened, the item will be dated with the date of which it was opened. The policy further directed to store, prepare, distribute and serve food in accordance with professional standards for food service safety and left over food items can be kept stored for up to 7 days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. The facility failed to follow hand hygiene and gloving practices consistent with accepted standards of practice for 1 of 2 residents reviewed (Residents #1). The facility reported a census of 35 residents. Findings include: Resident #1 ' s Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #1 required supervision or touching assistance with rolling in bed and was dependent on staff to sit up or lay down in bed. The MDS identified Resident #1 required a mechanical lift and was dependent on staff for transfers and toileting. Resident #1 ' s MDS included diagnoses of anemia, hypertension (high blood pressure), multidrug-resistant organism, diabetes mellitus, malnutrition, right below the knee amputation, and left great toe amputation. The MDS coded Resident #1 had diabetic foot ulcers and received applications of dressings to feet. A facility form titled Non Pressure Sore Skin Conditions dated 6/7/23 revealed Resident #1 had an incision site to the left great toe from an amputation. The form documented on 8/7/24 the incision site measured 1.8 cm (width) (centimeters) x 1 cm (length) x 0.1 cm (depth). The wound appearance was light red and dark pink. The form revealed there was a small amount of bloody drainage from the incision site after the bandage was removed and the bleeding stopped after Resident #1 had a shower. A Physician Order dated 7/3/24 directed staff to cleanse the left great toe amputation site with normal saline, apply hydrofera blue (antibacterial foam dressing) ready dampened with normal saline to the wound bed, cover with foam and Mefix tape on Monday, Wednesday and Friday. On 8/7/24 at 9:28 AM, observed Staff A, RN (Registered Nurse) complete dressing change to left great toe amputation site. Staff A washed her hands and applied gloves. Staff A got wound care supplies ready using paper towels as a barrier. Staff A took a new bottle of saline, dampened a piece of gauze and placed it on the paper towel. Staff A then cut the hydrofera blue dressing with a pair of scissors, dampened the piece of hydrofera blue with the saline and placed it on the paper towel. Staff A with gloved hands searched through the pink bin of dressing supplies for a piece of foam. Staff A placed the piece of foam on top of the paper towels. Staff A carried the dressing supplies on the paper towel over to the bedside. Staff A cleansed the left great toe amputation site with the gauze pad while wearing the same gloves she had worn to gather supplies/touched multiple surfaces. After cleansing the wound, Staff A removed the gloves, took a new pair of gloves from the glove box on the wall and then sat the new gloves down on the sink. Staff A washed her hands and applied the gloves that were sitting on the sink. Staff A applied the hydrofera blue dressing to the amputation site, then covered the area with foam and secured the foam with tape. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 10:15 AM, Staff A, RN verified and acknowledged she should have completed hand hygiene and changed gloves before cleansing the wound. Staff A also acknowledged she should have washed her hands after removing gloves and before taking the gloves out of the box and not sat the gloves down on the sink. On 8/7/24 at 2:45 PM, the Director of Nursing reported she would expect staff to change gloves and complete hand hygiene between dirty and clean procedures. The undated facility policy titled Standard Precautions directed the following: a. Hand Hygiene- practice hand hygiene after touching blood, body fluids, secretions, excretions, or contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. b. Gloves- Wear gloves when touching blood , body fluids, secretions, excretions, or contaminated items. Put on clean gloves just before touching mucous membranes and non intact skin. Change gloves between tasks and procedures. Practice hand hygiene whenever gloves are removed.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 49056 Based on review of facility policy, staff interview and record review the facility failed to follow an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for 1 resident (Resident #26). The facility reported a census of 35 residents. Findings include: The facility form named Nursing Home Physician Fax reported a new order for Resident #26 from the physician dated 1/11/23 for Methenamine 1 Gram, 1 tablet twice daily by prophylactic for urinary tract infection with no end date. The current Clinical Physician ' s Orders dated 8/8/24 for Resident #26 documented Resident #26 continued with the order for Methenamine 1 Gram, take 1 tablet by mouth twice daily related to urinary tract infections. The clinical record lacked documentation that the facility monitored the long term use of Resident #26 ' s antibiotic. An interview on 8/8/26 at 9:30 AM the Infection Preventionist (IP) stated they have a system in place to monitor long term use of antibiotics to assure they were still necessary. The IP revealed they generally review them once a year. An interview on 8/8/24 at 11:30 AM with the Pharmacy Consultant verified that she had addressed the prophylactic antibiotic in January 2023 but voiced she would have liked the facility IP to have followed up on it. The facility policy with an effective date of 12/26/2017 named Antibiotic Stewardship revealed the facility goal is to develop, promote, and implement an antibiotic stewardship system to monitor the use of antibiotics. Monitoring includes optimizing the treatment of infections by ensuring administering antibiotics only when needed, working collaboratively with the consulting pharmacy and provider to prescribe antibiotics only when clinically indicated, ordering the appropriate antibiotic, duration of administration for each infection.