STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165532	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracewell, an Eventide Community	114 South 20th Street Denison, IA 51442

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on resident record review, facility policy review, staff, resident, and family interviews, the facility failed to verify a resident's Advanced Directives choice for 2 of 24 residents reviewed (Residents #8 and #58). The facility reported a census of 71 residents. Findings include: 1. Resident #58's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of Alzheimer's and bipolar disorder. Resident #58's Free Choice of Health Care Services signed by his sister on [DATE], marked he wanted cardiopulmonary resuscitation (CPR) should his heart stop beating. The Physician telephone order dated [DATE] and signed by the physician on [DATE] reflected an order for Resident #58 to be a do not resuscitate (DNR) per family wishes. The Care Plan Focus dated [DATE] reflected Resident #58's Advanced Directives as DNR. Upon revision on [DATE], the Care Plan indicated DNR [DATE] CPR per Resident #58's wishes. The Interventions revised [DATE] directed to honor Resident #58's wishes: [DATE] - DNR per Resident #58's and family's wishes. On [DATE] CPR per Resident #58's wishes. Interview on [DATE] at 11:07 AM, Resident #58's sister, with Resident #58 in attendance, reported his Advanced Directive as CPR when he was admitted . The facility approached them about Resident #58's code status and his siblings chose for him to be a DNR. Resident #58's sister reported being up in the air with CPR or DNR. She explained CPR and DNR to Resident #58 and he stated he wanted CPR. Resident currently has a BIMS of 15. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 3:18 PM, Staff F, Nurse Manager, stated she spoke with Resident #58's sister earlier that day. She reported Resident #58 wanted CPR for his Advanced Directives status. Staff F stated that during a care conference in the past, the siblings spoke to the facility and wanted the advanced directive changed from CPR on admission to DNR status. Staff F stated the facility's protocol is to fill out a physician telephone order slip with the code status change for the physician to sign. Staff F also stated they don't redo the initial form filled out on admission and signed by the resident or family. Staff F acknowledged Resident #58 had a BIMS of 15, and the facility didn't have a physician's note deeming him as incompetent to make his own decisions, they didn't have any documentation that someone talked to the family or Resident #58 about his code status. The facility only had the physician's order slip signed by the physician that documented the DNR per family's wishes, and should have something signed by family. 41785 2. Resident #8's MDS assessment dated [DATE], identified a BIMS score of 5, indicating severe cognitive deficit. Resident #8 required substantial assistance with dressing, hygiene, transfers and toileting. The MDS included diagnoses anemia (low blood iron levels), peripheral vascular disease (impaired blood circulation) and non Alzheimer's' dementia. The Care Plan Focus revised [DATE] reflected Resident #8 wanted DNR as their Advanced Directive wishes. The Intervention instructed the staff to provide education as requested or needed regarding Advanced Directives and maintain a copy of her code status in the chart. The Care Plan Focus revised [DATE] indicated Resident #8 had impaired cognitive function and impaired thought processes related to dementia. Resident #8's Free Choice of Health Care Services form signed by her niece on [DATE], indicated she wished for CPR, should her heart stop. The Communication - with Physician dated [DATE] at 10:17 AM identified Resident #8's family changed Resident #8's code status to DNR. The chart lacked a second form for the change in code status on [DATE]. On [DATE] at 6:40 AM, the Director of Nursing (DON) said they reviewed code status wishes with families at the quarterly care conferences. She pointed out a separate line on the form titled: Review Advanced Directive, where it was documented CPR or DNR. Another line on the form was titled; Phone Call to, where they documented the name of the resident's representative and phone number. A Care Conference note dated [DATE] identified the Review of Advanced Directives box indicated CPR. The form included Resident #8's Representative's name and phone number, the document lacked a signature of the representative. A Care conference note dated [DATE], reflected the Review of Advanced Directives box unchecked and documented; DNR per family. The line titled; Phone Call To, included the name of the representative with several phone numbers. The form lacked documentation that they could to talk to the family representative. The form lacked a signature of the representative. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:10 PM, Staff F, Unit Manager, said they put the phone numbers on the care conference line for the family member so they could contact them during the care conference. She acknowledged they didn't document if they actually got ahold of the family. She acknowledged they should follow up and get a signature especially when they had a code status change. The Residents' Rights Regarding Treatment and Advance Directives policy, dated [DATE], directed the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.

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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** 41785 Based on observation, interview, and record review the facility failed to identify new skin issues in a timely manner for 2 of 4 residents reviewed (Residents #29 and #66). Resident #29 had an abdominal pressure ulcer, their clinical record lacked documentation until the area showed signs of infection. Resident #66 had bruising and a skin tear on her lower leg. The facility didn't discover or document the skin tear until after it scabbed over. The facility reported a census of 71 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. 1. Resident #29's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. He required substantial assistance with dressing and hygiene. The MDS listed him as totally dependent for transfers, toileting, and turning in bed. The MDS included diagnoses of heart failure, basal cell carcinoma (cancer) of skin, and type 2 diabetes mellitus. The MDS indicated Resident #29 didn't have pressure injures. According to a Wound Clinic note, dated 2/27/24, Resident #29 had 2 unstageable pressure injuries at that time; 1 to the right heel and 1 on the anterior (front) of the right foot. The Care Plan included the following Focuses dated: a. 8/14/24 identified Resident #29 had a terminal prognosis related to chondrosarcoma and received system management of his terminal illness by hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. 1/31/23 indicated Resident #29 had an activities of daily living (ADLs) self-care performance deficit related to heart failure, diabetes mellitus measured by activity intolerance, weakness, impaired balance, and new placement. The Interventions directed the staff to: i. Follow skin prevention protocols. He had self care performance deficit related to heart failure diabetes mellitus and impaired balance. ii. Inspect the skin and observe for redness, open areas, scratches, cuts bruises, and report to the charge nurse. C. Revised 8/16/24 reflected Resident #29 took Lantus related to diabetes mellitus. The Interventions directed the staff to: i. Check all of his body for breaks in skin and treat promptly as order by the physician. ii. Inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness. On 10/29/24 at 10:51 AM, observed Staff A, Registered Nurse (RN), provide Resident #29's wound treatments. Witnessed Resident #29 had a blackened ulcer on his right heel, an open oozing wound on the top of his right foot, and a deep ulcer under the abdominal fold on his right side. Staff A said the injury under the folds presented first as a pimple, then suddenly opened up, and had extensive drainage. After Staff A completed Resident #29's treatments and wrapped his right foot, she learned he had a spot under his right leg on the lower calf area. She said didn't know of the spot and proceeded to measure the abrasion. A nursing note on 10/29/24 at 12:06 PM, showed that the abrasion to the lower calf measured 0.5 centimeters (cm) x 0.5 cm, circular and red in the center. The resident was unsure how he got it. Resident #29's clinical record identified the first reference of a developing skin issue under the right abdominal fold in a nursing note created on 3/8/24 at 8:20 AM, for the date of 3/7/24 at 11:53 AM. The documentation described the skin issue as an area to the right groin having small drainage. The chart lacked description of the source of the drainage. The Health Status Note dated 3/8/24 at 3:30 AM, reflected Resident #29 had drainage of white, greenish pus, and bloody discharge in his right groin area, area harden 2 inches into the groin/scrotum area. The Physician/Nurse Communication Report dated 3/8/24, documented Resident #29's right groin crease had a lot of drainage. The drainage went from greenish to pus then bloody. Resident #29 had facial grimaces with cleansing. The staff couldn't keep the area dry due to the amount of drainage. The doctor replied with orders for a warm moist pack to her right thigh area for 15-30 minutes four times a day for seven days and Cephalexin 500 mg 1 by mouth 3 times a day, or every 8 hours for 7 days. They would see her on 3/11/24. Resident #29's Nursing Notes from 3/7/24 3/11/24 included the amount of drainage in the groin wound and their response to the antibiotic. The chart lacked measurements and further descriptions of the wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The handwritten Physician's Orders and Progress Notes dated 3/11/24 reflected the provider rechecked Resident #29's right groin abscess, following the order of warm packs and antibiotic. Resident #29's wound culture remained pending. They denied fevers, chills, or increased pain in the right groin area. He complained of itching in his left groin that appeared to have excoriation (red irritated skin). The right groin exam revealed an area of firmness down into the right inner thigh. The groin had a small opening where the abscessed drained. Only a scant amount of bloody drainage observed. The provider gave orders for Lortisone cream to the affected red itchy areas twice a day as needed for dermatitis/yeast. The orders included to place a 4 by (x) 4 in the right groin over the abscess area and apply a paper towel to the left groin area. The nursing note from 3/11 3/18 made a reference to antibiotic reaction and continued drainage, but lacked compete documentation of size and color of the wound. A review of a form titled: Wound Documentation from 3/18/24 to 4/15/24, showed the first detailed description of the right groin wound 3/18/24. The form described the wound as an abscess measuring 1 cm x 0.5 cm with bloody drainage, and a purplish surrounding base. The wound edges denudation (denuded wound is an injury that occurs when the protective top layer of the skin is gone, leaving the underlying tissue exposed.) The documentation lacked staging. A Wound Clinic note dated 4/1/24, indicated Resident #29 had a right groin ulcer, described as a Stage II blister with bloody drainage. Upon inspection the base appeared boggy with an appearance of old instant blood return. The wound had ecchymosis (bruising) around the opening. It appeared as if the skin had gotten pinched or rubbed. The anticoagulant medications caused increased bleeding. The wound measured 1.4 cm. length x 0.7 cm. width x a depth of 0.5 cm. The area appeared boggy, with a peri wound with ecchymosis. On 10/31/24 at 8:34 AM, the Wound Clinic RN said something caused the area to break open and started the drainage from under the surface. She said deep tissue injuries could first present as bruising, especially when a resident used anticoagulants, the medication helps to feed the wound. She said given the wound oozed, he may have had bruising before the break in the skin. Resident #29's March 2024 Medication Administration Record (MAR) listed an order for Apixaban (anticoagulant) 5 milligrams (mg) twice a day. On 10/30/24 at 3:09 PM, Staff D, RN, said they didn't have scheduled skin assessments but documented when they identified an issue. Once they found new area they would complete weekly assessments. She said that they didn't do scheduled full body skin assessments and relied on recognizing areas through daily observation during cares. On 10/31/24 at 11:12 AM, Staff F, Unit Manager, described the Certified Nurse Aides (CNA's) as the eyes and ears of the nurses. They did regular monitoring for any new skin issues and reported them to the nurses. She said the nurses often helped with daily cares and they always watch for any concerns. She maintained the groin issue originated with a pimple and just exploded. Staff F said that on 3/7/24 someone came to her about it and they contacted the doctor, the next day it started oozing. She said they didn't document it on a skin sheet because it didn't seem like a concern at that time. She acknowledged they didn't start a wound documentation sheet until 3/18/24. She said they started the wound sheets on Mondays. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #66's MDS assessment dated [DATE], identified a BIMS score of 6, indicating severely impaired cognition. She required substantial assistance with dressing, showers, and moderate/partial assistance with sit to stand and toilet transfers. The MDS included diagnoses of arthritis, osteoporosis, cerebrovascular accident (CVA or stroke) and non Alzheimer's dementia. The Care Plan Focus dated 6/13/24, indicated Resident #66 had the potential for excess bruising and/or bleeding related to the use of aspirin for her history of cerebral infarction (stroke). The Interventions directed the staff to monitor for excess bruising/bleeding with cares. Resident #66 admitted to hospice for system management of her terminal illness. A nursing note dated 10/28/24 at 3:00 AM, reflected a CNA reported a new area to Resident #66's left lower leg. The bruise measured 5.5 cm x 4.0 cm. On a side of the bruise had 2-line scabs each measuring 1.0 cm. The second bruise above measured 1.5 cm x 1.0 cm. Resident #66 couldn't recall what happened. On 10/30/24 at 2:43 PM, observed Staff C, RN, take Resident #66 to her room and pull up her pant leg to reveal two small scabbed areas. Around the scabs, the skin looked purple and slightly raised. She couldn't describe how it happened. On 10/31/24 at 11:12 AM, Staff F said that she didn't know why the bruising and skin tears on Resident #66's left leg didn't get discovered sooner, because by the time they found them, they scabbed over. On 10/30/24 at 4:10 PM, the Administrator and the Director of Nursing (DON) said the staff did a good job of watching for new skin issues. They said the CNAs didn't do assessments, but alerted the nurses to any concerns. They indicated the nurses help with a lot of the resident cares so they also have eyes on the resident's skin to monitor on a regular basis. A facility policy dated October 2023 titled: Skin Care, described the purpose of the policy as to give immediate assessment and treatment to all areas of the skin where tissue damage occurred and to prevent further skin damage. The direct care staff completed daily skin care through observance of any red, open, discolored areas and immediately reported the change in skin to the charge nurse. The assigned nurse would complete the weekly skin care documentation for a specific area on all residents with current and/or potential problems.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40905 Based on observation, policy review, resident, and staff interview, the facility failed to prepare food that conserved flavor, appearance, and palatable for a lunch meal. The facility reported a census of 71. Findings include: Interview on 10/28/24 at 11:39 AM, Resident #15 stated the food is often overcooked and burnt at times, especially the meat. Interview on 10/29/24 at 9:33 AM, Resident #45 stated the food is bland, just didn't taste good. They described the meat as tough and unable to cut it. During continuous observation on 10/30/24 starting at 9:25 AM, Staff G, Cook, placed 5 pans of chicken nuggets into the oven to bake. At 9:40 AM they placed a pan of fish fillets into the oven to bake. At 9:50 AM, when Staff G checked the temperature of the chicken, it registered at 180 degrees Fahrenheit (F), and at 10:10 AM the fish fillet temperature registered at 174 F. Staff G left the chicken and fish in the oven. On 10/30/24 at 12:30 PM after the staff completed serving the lunch meal, the facility provided a test tray of sesame chicken, Asian blend vegetables, and fried rice. The sesame sauce appeared to soak through the breading of the nugget, no liquid sauce. The chicken nuggets too tough to cut with a fork only, but able to cut with a knife. The nuggets tasted dry with a moderate amount of work needed to chew the chicken thoroughly. The vegetables were mushy as able to mash all vegetables down to almost a puree consistency with a fork. They looked so overcooked couldn't differentiate the difference of each vegetable as the color of them all appeared the same greenish/brownish color. Interview on 10/30/24 at 1:30 PM, Resident #15 described the lunch meal as not good. Resident #15 reported he had the sesame chicken. He detailed the chicken as over cooked, very dry, with no sesame sauce on the chicken, and overcooked, mushy vegetables. Interview on 10/31/24 at 10:30 AM, the Dietary Manager agreed the vegetables served for the lunch meal the day before were very mushy and stated they expected the staff to provide residents a palatable meal. The facility policy, Food Preparation Guidelines dated 2/1/24, instructed food shall be prepared by methods that conserve nutritive value, flavor, and be palatable.

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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** 41785 Based on observation, interview and record review the facility failed to practiced adequate hand hygiene for 1 of 4 residents reviewed (Resident #3) for infection control measures. As the nurse administered Resident #3's medications via a feeding tube, she failed to change her gloves after she had contact with several surfaces. The facility reported a census of 71 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS listed Resident #3 as totally dependent on staff for toileting, dressing, sit to lying, chair to bed transfer, and toilet transfers. The MDS included diagnoses of aphasia (difficulty speaking), cerebrovascular accident (CVA or stroke), neurogenic bladder (trouble with urinating either too much or not enough) and anemia (low iron in the blood). The Care Plan Focus dated 7/25/24, indicated Resident #3 required enhanced barrier precautions related to a history of C-diff (clostridium difficile bacterial infection in the large intestine) and a feeding tube. The Care Plan Focus revised 8/26/24 reflected Resident #3 had a nutritional risk. She couldn't have anything by mouth due to a history of dysphagia (difficulty swallowing) and receiving 100% of her nutrition and hydration by her G-tube. On 10/29/24 at 8:48 AM, Staff A, Registered Nurse (RN), prepared Resident #3's medications for administration into the PEG (Percutaneous Endoscopic Gastrostomy or feeding tube) tube. As Resident #3 laid in bed on her back, Staff A stood on one side of the bed and a nursing student on the opposite side. They each grabbed the protective pad under Resident #3 and slide her up in bed. Once up in the bed, Staff A failed to change her gloves or complete hand hygiene as she prepared the water and medications to administer. On 10/31/24 at 11:12 AM, Staff F, Nurse Manager, said she taught the staff to change their gloves and practice hand hygiene after touching surfaces that could possibly be contaminated. She said Staff A should have removed her gloves and performed hand hygiene before preparing the medications. A facility policy for PEG Or G Tubes, dated October 2023, indicated that residents with G Tube feeding would be cared for as ordered per physician, with emphasis on infection control and resident comfort. The Hand Hygiene policy dated February 2024, directed all staff to perform proper hand hygiene procedures to prevent the spread of infection.