STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Woods Care Center	Three Pennsylvania Place Ottumwa, IA 52501

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 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** 34817 Based on clinical record review, observations, staff interviews, and policy review, the facility failed to process physician orders, and failed to provide and document physician ordered treatments such as wound care and dressing changes for 1 of 5 residents reviewed for skin conditions. The facility also failed to document a change in skin condition and the treatment interventions initiated for 1 of 5 residents reviewed for skin conditions (Resident # 32). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had diagnoses of heart failure, anemia, and Alzheimer's disease. The MDS indicated the resident had no skin issues. The Care Plan initiated 6/3/24 and revised on 9/3/24 revealed Resident #32 had abrasions to the left and right knee, top of her right foot, and right pinky toe/nail. The Care Plan directed staff to administer treatments as ordered, monitor for effectiveness, and document skin breakdown measurements. The electronic health record Progress Notes revealed the following: a. On 8/24/24 at 7:00 AM, skin tear on left shin 1.0 centimeter (cm) x 1.5 cm. Cleanse wound with wound cleanser, pat dry, cover with xeroform and a medipore dressing every AM (morning) and PRN (as needed) until healed. b. On 9/1/24 at 4:30 AM, cleanse all abrasions with wound wash and pat dry. Cover the right foot areas #1 and #2, right knee, left knee, right shoulder, and right pinky toe with xeroform, non-adherent pad, and gauze every day until OTA (open to air). An intervention note included to administer treatments as ordered and monitor for effectiveness. c. On 9/3/24 at 1:08 PM, the Assistant Director of Nursing (ADON) documented to discontinue current treatment to the foot and legs. New order obtained to cleanse the knees and right foot, cover with TAO (triple antibiotic ointment), and leave the areas OTA daily until the area healed. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 9/10/24 at 12:59 PM, the ADON documented to cleanse the left knee with wound wash, cover with hydrofera blue and a gauze wrap daily. Cleanse the right knee, cover with xeroform, telfa, and a gauze wrap daily. An Incident Report revealed on 9/1/24 at 4:05 AM, a CNA (certified nursing assistant) passed by the resident's room and observed her empty bed. The CNA entered the room and found the resident in a prone position alongside the bed on the floor, and a body pillow on top of her. The resident's bilateral knees had abrasions and the right shoulder had a small abrasion and ecchymosis (bruise). Abrasions cleansed with wound wash, and covered with xeroform, a non-adherent pad, gauze and tape. A Memo to the Physician (Dr) dated 9/1/24 revealed the resident found on the floor in a prone position next to the bed. The resident had superficial abrasions on her knees, the top of her right foot, and her right upper arm. No mass or lacerations noted. The resident surely must have hit her head due to the back of her head found against the bed. The resident moved all extremities, and able to bear weight without complaints. The right pinky toe toenail hung loosely. All areas cleansed with wound wash, and a xeroform and a non-adherent dressing applied. Dressing changes (to be completed) on the PM (evening shift). The Physician's Telephone Orders revealed the following: a. On 8/30/24: a skin tear on the left shin had scabbed over. Order to apply skin prep to the left shin area every AM for 7 days. b. On 9/1/24: cleanse all abrasions with wound wash and pat dry. Cover the right foot, right knee, and left knee with xeroform, non-adherent pad, and a gauze roll. Change the dressing daily until OTA. c. On 9/3/24: discontinue current treatment to the foot, legs, and shoulder. A new order to cleanse the knees and right foot areas, then apply TAO daily, and leave areas OTA until healed. The Order Summary Report revealed the following orders: a. Cleanse areas to bilateral knees and right foot with wound cleanser and pat dry. Cover areas with a thin layer of TAO, and leave OTA daily for wound healing had a start date 9/3/24. b. An order to cleanse bilateral knee abrasions with wound cleanser, pat area dry, then apply xeroform, telfa (a non-adherent dressing), and rolled gauze daily had a start date 9/9/24. c. Cleanse left knee with wound wash, cover with hydrofera blue, and wrap with gauze daily had a start date 9/11/24. d. Cleanse abrasions to right knee with wound cleanser and pat dry. Apply Xeroform, telfa (a non-adherent dressing), gauze, and tape daily started on 9/11/24. The Non-pressure Skin Condition Report dated 9/1/24 revealed the following: a. Left knee abrasion 5.5 cm x 4.5 cm (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:24 AM, Staff C and the DON entered the resident's room. The DON looked at the resident's left knee wound and reported she planned to call the Dr to get a different treatment order. At the time, the DON asked the resident if her right knee hurt. Resident #32 responded Oh yea, the pain is all the way down there. Staff C measured the wounds and wrote the numbers on a piece of paper: Right knee: 2 cm x 1 cm Left knee: 3 cm x 6.5 cm The DON left the room. At 11:28 AM, Staff C donned a pair of gloves then applied xeroform, telfa, and gauze to the right knee wound. Staff C dated and initialed the dressing. At 11:39 AM, the DON returned to the room and provided supplies to Staff C. The DON told Staff C she would write the order received from the Dr. Staff C applied gloves and proceeded to apply sterile water to a piece of hydrofera blue foam dressing, then applied the hydrofera blue and a rolled gauze dressing to the left knee wound. During observation on 9/10/24 at 1:50 PM, Staff D, CNA, provided cares and assisted the resident into bed. Staff D removed the gripper sock on the resident's feet. The top of the resident's right foot had a border foam dressing and a large dark area of drainage that bled through the dressing. The dressing and tape had no date and no initials. At the time, Resident #32 reported her toe hurt when she walked and her foot caught on the floor. During an interview on 9/10/24 at 12:29 PM, Staff C reported she wrote the Dr's order on a Telephone order form whenever a new order was received. She also entered the order into the computer, faxed the order to pharmacy, wrote the order on the MAR (medication administration record) or TAR, and wrote a note in nurse's Progress Notes about the order and what was done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 2:00 PM, the surveyor approached Staff C and asked about the treatment to Resident #32's foot. Staff C reported she didn't know anything about a treatment for Resident #32's foot. She last saw the resident on Tuesday, 9/3. The resident had a fall on 9/1/24. Staff C reported she normally did resident skin treatments on Mondays but she was not at the facility the past Monday due to the holiday, so she completed the residents' skin assessments and treatments on Tuesday, 9/3/24. On that day, Resident #32's foot had a scab over it, and she applied TAO and left it OTA. At the time, Staff C obtained some supplies and entered the resident's room with the surveyor. Staff C washed her hands, donned gloves, and removed the gripper sock on the resident's right foot. Staff C confirmed the dressing had no date or initials. Staff C stated she was uncertain when the dressing had been applied or last changed. Staff C reported the wound to the top of the foot had a lot of slough in it. The wound had redness around it. Staff C reported the wound was superficial and had a scab and almost healed the prior week. Staff were supposed to put TAO and OTA. She didn't know why or who covered the area. Staff C stated she planned to call the Dr to see about a treatment to the area. She thought the Dr would want therafera blue to help remove the slough. Staff C then removed the broken toenail from the resident's right little toe. Staff C reported to the surveyor the non-pressure skin condition reports for Resident #32's wounds were in Staff E's top desk drawer. She didn't know why the skin condition reports weren't in the treatment book. Normally the TAR and skin assessments were kept in the treatment book. Staff C recalled when she entered the order in the computer for TAO to the area, she printed it off and put it in the treatment book on 9/3/24. Staff C stated she didn't know why the TAR was not in the book today, but facility staff were sorting through papers and looking for it. On 9/10/24 at 2:15 PM, Staff C reported she spoke with the Dr and obtained an order for therafera blue and kerlix to the top of Resident #32's foot starting 9/10/24. Staff C reported she would enter the order. During an interview 9/10/24 at 2:18 PM, Staff E, RN, reported whenever she received a Dr's order, she wrote the order on a Telephone Order form, documented the order in the hard chart (paper) nurse's notes, wrote the order on the MAR or TAR, and sent the order to the pharmacy if it's a medication or treatment order. Staff E explained the Telephone order form was a triplicate form. The original form placed in the resident's chart, the yellow copy was sent to the DON, and the pink copy sent to the ADON/Care Plan Coordinator. Staff E reported the nurses helped enter orders whenever they had a stack of orders to process. Staff E reported skin assessments documented on a non-pressure skin record or pressure wound record. Staff C, Staff E, and the DON completed follow up skin assessments with measurements weekly. They determined if the wound or skin concern improved or deteriorated. Staff E reported she had covered a lot of night shifts so she hadn't been doing the skin assessments unless she found a new skin concern during her shift. Staff E stated she did treatments as ordered and called the Dr if a wound had not showed improvement. Staff E reported when staff found Resident #32 on the floor (9/1/24), she assessed the resident. The resident had abrasions to her knees and right foot. She wrote an order to apply xeroform and kerlix because the wounds looked wet. She suspected the treatment would change to TAO and OTA in a couple of days. She filled out the treatment record form and placed the form in the treatment book, but she had a couple things to write on the skin report so she put the skin report papers in her desk drawer to finish later. Resident #32 just had the abrasions. She planned to come in on Monday to finish filling out the skin record and sign the document but she got distracted and didn't get it done. That's why the forms were still in her desk drawer. She figured the nurse would just measure the areas each week. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 2:40 PM, Staff E provided the surveyor the orders she wrote on the TAR on 9/1/24 and reported her initials as the only entries signed off on the treatment on that day only. The TAR had no other staff initials listed 9/1/24 to 9/10/24. During an interview on 9/11/24 at 8:09 AM, the physician reported when he wrote an order, he expected or hoped staff carried out the order, such as a treatment. He reported the facility staff let him know if a medication or treatment was not available or a reason why a treatment should not be carried out. He expected staff to notify him if a wound got worse. The physician reported wounds could be tricky. He gave staff [NAME]-way especially if they were familiar with wound care. The facility had standing orders for nurses to initiate a wound treatment based on an assessment. He gave the nurse discretion about what to do until he could visualize the wound himself. The physician reported he had not seen Resident #32 since she had the fall but he was aware of it and the wound treatment implemented. During an interview 9/11/24 at 10:39 AM, the DON reported Staff C obtained wound measurements weekly. The facility had standing orders for nurses to implement a treatment until the Dr came to the facility and assessed the resident. During an interview 9/11/24 at 2:21 PM, the ADON stated she was also the MDS/ Care Plan Coordinator. The ADON reported she wasn't working on the day Resident #32 had a fall. She entered a nursing Progress Note in the EHR, then went into the resident's Care Plan and entered a comment to administer the treatment as ordered. She entered a comment whenever she updated or revised the Care Plan so she could track the changes and when they occurred. The ADON demonstrated on the computer the steps she took when she entered information into the Care Plan. She confirmed a revision on 9/3/24 on Resident #32 because the resident had a change in wound treatment. The ADON reported she only entered the information on the resident's Care Plan. The DON and Staff C entered the Dr's order into the computer and do what they needed to do to process the order. The ADON explained the process for when an order received. Order written on a telephone order form. The order form is a triplicate form. The white (original) was placed in the Dr's box to review and sign, the pink form went to the ADON to enter the information into the resident's Care Plan or MDS, and the green form given to the DON or Staff C to process the order. The white copy of the form got placed into the paper chart after the Dr signed off on the order. The ADON reported Staff C performed the skin assessments on residents with wounds each week but Staff F performed the skin assessments before Staff C took it over. During an interview 9/11/24 at 2:29 PM, Staff F, RN, reported she was the person designated to do skin assessments a while back but had not done the skin assessments since 5/2024. Staff C, RN, responsible for performing skin assessments since 5/2024. The skin assessment performed weekly on residents with wounds or a skin concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 9/12/24 at 9:44 AM, the DON reported she came into the facility on the evening of 9/2/24 to report a COVID positive case at the facility. Staff H, RN, requested her to look at Resident #32's knees and foot. The DON stated she observed the areas. The areas looked dry and scabbed over. She told Staff H to start TAO and Staff C would look at the area the next day. The DON reported she couldn't find Resident #32's skin sheet or TAR. She found the TAR for September in the resident's paper chart, not in the treatment book. She was not able to find Resident #32's skin records but then found them in Staff E's desk this week after the surveyor asked for them. The DON reported Dr's order faxed to pharmacy, but the order not faxed to pharmacy whenever treatment supplies used from their stock. The DON reported Staff G, RN, changed Resident #32's treatment and implemented a standing order for xeroform because the resident's left knee area was too dry and had cracked open. The standing orders gave the nurses discretion to implement treatments for skin tears and abrasions. The DON reported Staff G didn't chart the change in treatment or write the order for the xeroform treatment when she initiated this treatment. The DON reported she expected staff to follow orders and document when treatments performed. The DON reported there were paper records everywhere. Staff had trouble deciphering some documentation and she had to call a nurse to have her relay the notes she wrote. The DON reported Staff E wrote the Incident report and the memo to the Dr about Resident #32's fall and abrasions. During an interview 9/12/24 at 9:54 AM, Staff G, RN, reported Resident #32 had a treatment order that Staff E wrote but Staff E's handwriting was awful. Staff G stated she couldn't read the order. Staff G reported when she came into work over the weekend on 9/8, no TAR found for Resident #32. She had just arrived to work when a CNA came and told her Resident #32's leg was bleeding and she wanted her to look at it. She looked at the area and then cleaned it. Staff G reported the resident's knees were scabbed over, but one knee had cracked open. Staff C oversaw the wounds but since Staff C not working and it was over the weekend, Staff G applied Vaseline and a kerlix over the area. She planned to write the order but it was a crazy day and she didn't get the order written before she left for the day. She wasn't 100 % sure what Staff C would want on the wound but she felt she needed to do something. Staff G explained they had standing orders and it was at the nurse's discretion on what treatment to use. She did what she thought would be the best treatment. Staff G confirmed she did not document a Nurse's Note when the resident's knee had bleeding, the steps she took, or the treatment performed. Staff G reported she couldn't find the TAR so she didn't document the treatment on the TAR either. An undated non-pressure skin condition assessment policy revealed weekly skin assessment of skin conditions documented on non-pressure skin assessment sheet to help prevent infections or other complications for all non-decubitus skin lesions and assure documentation of the healing. All skin conditions such as open areas or abrasions assessed and documented on a non-pressure skin sheet. Subsequent weekly documentation should show the response to treatment as well as a description of the size and appearance of the affected areas. Signs of infection or poor response to treatment reported to the physician. A Physician Order Transcription policy effective 7/2023 revealed orders received and orders transcribed by a nurse onto an order sheet in the patient's chart. Orders signed, dated, timed, and noted at the time it is written on the order sheet or entered into the computer system.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34817 Based on observations, staff interview, and policy review the facility staff failed to serve food under sanitary conditions to prevent food borne illness during 1 of 2 meals observed. The facility identified a census 58 residents. Findings include: During observations on 09/10/24 at 8:40 AM, the Social Services designee peeled a banana for residents in the main dining room, then used her bare hand to remove the banana from the banana peeling and gave the banana to the resident or placed the banana onto the resident's plate. At 08:44 AM, Staff A, certified nursing assistant (CNA), peeled a banana for a resident, then used her bare hand to place the banana onto the resident's plate. Staff A then picked up a slice of toast, placed the bread in the palm of her bare hand and took a knife to apply jelly onto the toast. Staff A then placed the toast onto the resident's plate. During an interview 09/11/24 at 12:50 PM, the Food Service Supervisor reported staff should use a fork or something to hold ready to eat foods such as when they removed a banana peeling, or put jelly or butter on bread. The Food Service Supervisor stated staff could also wear a glove or use a paper towel to hold the food, but staff should not directly touch the resident's food. The facility's General Food Preparation and Handling policy dated 2013 revealed food items prepared to keep free of injurious organisms and substances. Bare hands should never touch raw food directly. Food such as bread or other items served with tongs, fork, or other suitable implements to avoid manual contact of prepared foods.

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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. 34817 Based on clinical record review, observation, staff interview, and facility policy review, the facility failed to follow infection control techniques to prevent the potential spread of infection for 1 of 1 residents on transmission-based precautions (Resident #19). The facility reported a census of 58 residents. Findings include: The Diagnosis Report revealed Resident #19 had an onset of COVID-19 on 09/02/24 that was acquired during his stay at the facility. The Care Plan initiated 09/30/21 and revised on 09/03/24 revealed Resident #19 had tested positive for COVID-19 and placed in isolation on 09/02/24. The paper Nurse's Notes revealed on 9/2/24 at 1:20 PM, resident not feeling good. A Covid test done and it was positive. The DON (Director of Nursing), physician, and son notified of positive Covid test. Resident placed in isolation precautions. Observations revealed the following: a. On 09/09/24 at 2:20 PM, a plastic bin with drawers sat outside Resident #19's room. The drawers had personal protective equipment (PPE) (gowns, N95 masks) inside. A box of surgical masks sat on top of the cart, and a container of sanitizing wipes and a box of gloves sat on the handrail in the hallway by the resident's room. The door and area by the resident's room and plastic bin had no signage posted to indicate a resident on isolation or transmission-based precautions (TBP), or the need to don PPE prior to entry into the room. b. On 09/09/24 at 2:23 PM, the surveyor asked Staff B, certified nursing assistant (CNA), about the PPE stored in the hallway area near Resident #19's room. Staff B reported Resident #19 in isolation because he had COVID. c. On 09/09/24 at 2:26 PM, Resident #19 coughed while he sat in a chair in his room. d. On 09/09/24 at 2:26 PM, Staff B, CNA, posted a sign on the wall by Resident #19's room labeled Contact / Droplet Precautions and another sign about the PPE required. Staff B reported Resident #19 was the last resident that tested positive for COVID. Staff B stated the resident would come out of isolation on 9/13/24. During an interview on 09/11/24 at 3:30 PM, the Director of Nursing (DON) reported no order written whenever a resident placed in isolation, they just followed the standard CDC's (Center for Disease Control) recommendations. During exit conference on 09/12/24 11:15 AM, the DON reported the isolation signage didn't get put up by the resident's room because the resident got placed in isolation over the weekend. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Isolation - Initiating Transmission-Based Precautions policy revised 8/2019 revealed TBP initiated whenever a resident developed signs and symptoms of a transmissible infection or had a laboratory confirmed infection and at risk of transmitting the infection to other residents. TBP included contact, droplet, or airborne precautions. The policy revealed when TBP's are implemented, the Infection Preventionist (or designee): a. Clearly identified the type of precautions, the anticipated duration, and the PPE that must be used. b. Determined the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors were aware of the need for and the type of precautions: (1) The signage informed the staff of the type of CDC precautions, the instructions for use of PPE, and/or instructions for visitors / staff to see a nurse before entered the room. (2) TBP's remained in effect until the attending physician or Infection Preventionist discontinued the precautions, which occurred after the criteria for discontinuation met.