

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Adel Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Greene Street Adel, IA 50003	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, hospital clinical record review, hospital images, staff interviews, and policy review, the facility failed to identify a resident with pressure ulcers/wounds and to assure the resident received treatment and services, consistent with professional standards of practice, to promote healing of ulcers/wounds for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 45 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers:</p> <p>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.</p> <p>Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, with slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.</p> <p>Stage III is 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.</p> <p>Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) which may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.</p> <p>Unstageable Ulcer: inability to see the wound.</p> <p>Other staging consideration include:</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin. 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.</p> <p>Resident #1's MDS (Minimum Data Set) assessment dated [DATE] identified a BIMS (Brief Interview for Mental Status) score of 13, indicating intact cognition. The MDS identified Resident #1 was dependent on staff with bed mobility and did not complete a transfer during the assessment period. The MDS documented Resident #1 was always incontinent of bowel and bladder. The MDS included diagnoses of neurogenic bladder (lack bladder control due to nerve damage), paraplegia (paralysis of the legs and lower body), malnutrition, depression, chronic obstructive pulmonary disease, respiratory failure, and adult failure to thrive. The MDS identified Resident #1 was at risk for developing pressure ulcers. The MDS documented Resident #1 had a pressure reducing device for the bed and application of non-surgical dressing.</p> <p>The Care Plan with target date 7/4/24 contained the following information:</p> <p>a. Resident #1 was bedfast all of the time per resident choice.</p> <p>b. Resident #1 had actual impairments to skin integrity related to history of pressure wounds. The Care Plan directed the following:</p> <p>Observe and document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, and maceration to the Physician- 4/27/19</p> <p>-Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short- 4/27/19</p> <p>-Encourage good nutrition and hydration in order to promote healthier skin- 4/27/19</p> <p>History of methicillin- resistant staphylococcus aureus (MRSA)- 01/18/2021</p> <p>Followed by wound care specialist monthly- 3/30/23</p> <p>Pressure relieving/reducing mattress and pillows to protect the skin while in bed- 4/27/19</p> <p>Use a draw sheet or lifting device for moving- 2/28/23</p> <p>Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations- 4/27/19</p> <p>A Progress Note dated 3/30/24 at 9:37 AM documented Resident #1 stated he felt like he was going to die and wanted to go to the hospital. Resident #1 refused peri care prior to the transfer. The note revealed, when discussing Do Not Resuscitate (DNR) status, Resident #1 stated he would like chest compressions and intubation.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note dated 3/31/24 at 1:07 AM documented Resident #1 was admitted to the hospital for shortness of breath and hypotension (low blood pressure). The note revealed Resident #1 was intubated (placement of a tube into the trachea to maintain an open airway) at the hospital.</p> <p>A Hospital record titled Integumentary- Pressure Ulcer assessment dated [DATE] at 4:00 PM documented Resident #1 had the following pressure areas on admission:</p> <p>A. Right Hip:</p> <ul style="list-style-type: none"> -Pressure Ulcer Wound Bed Description: Discolored -Pressure Ulcer Bed Color(s): Pink -Pressure Ulcer Wound Edge: Approximated -Pressure Ulcer Surrounding Tissue: Intact -Pressure Ulcer Drainage Amount: None -Pressure Ulcer cleanings: Soap and Water -Pressure Ulcer Dressing Type/Treatment: Foam with adhesive -Pressure Ulcer Comment: healing old pressure ulcer <p>B. Right Heel:</p> <ul style="list-style-type: none"> -Pressure Ulcer Stage: Unstageable -Pressure Ulcer Wound Bed Description: Dry -Pressure Ulcer Bed Color(s): Black -Pressure Ulcer Drainage Amount: None -Pressure Ulcer Cleansing: Soap and water <p>C. Left Heel:</p> <ul style="list-style-type: none"> -Pressure Ulcer Stage: Unstageable -Pressure Ulcer Wound Bed Description: Dry -Pressure Ulcer Bed Color(s): Black -Pressure Ulcer Drainage Amount: None -Pressure Ulcer Cleansing: Soap and water <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Hospital record titled Integumentary- Incision/Wound assessment dated [DATE] at 4:00 PM documented Resident #1 had the following skin areas on admission:</p> <p>A. Right and Left Groin:</p> <ul style="list-style-type: none"> -Type: Moisture Associated Skin Damage -Dressing Status: Left open to air -Wound Bed Description: Discolored, Partial-thickness -Wound Bed Color(s): Red -Wound Edge: Not Attached -Surrounding Tissue: Erythema -Drainage Amount: Minimal -Drainage Description: Sanguineous <p>A Hospital record titled Integumentary- Incision/Wound assessment dated [DATE] at 8:00 AM documented Resident #1 had the following skin areas/wounds on admission:</p> <p>A. Left Foot:</p> <ul style="list-style-type: none"> -Type: Venous insufficiency ulcers -Dressing status: Left open to air -Cleansing: Soap and water -Skin Treatment: [NAME] paste/ointment <p>B. Right Foot:</p> <ul style="list-style-type: none"> -Type: Venous insufficiency ulcers -Dressing status: Left open to air -Cleansing: Soap and water -Skin Treatment: [NAME] paste/ointment <p>Review of a Hospital image taken on 3/30/24 at 4:00 PM revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility form titled Shower Skin Observation on 3/12/24 and 3/25/24 documented both of the right and left foot/toes circled on the form indicating there were skin issues. The form was signed by a certified nurse assistant and a charge nurse.</p> <p>On 4/2/24 at 1:59 PM, Staff B, CNA reported Resident #1's right hip would get red sometimes but she did not believe it was opened. She stated Resident #1 had super dry flaky skin on his feet and sometimes they would bleed. She stated she would put a lot of lotion on Resident #1 with encouragement.</p> <p>On 4/3/24 at 9:58 AM, Hospital Registered Nurse (RN) reported she had completed a skin assessment on Resident #1 after admission to the hospital. She stated his right hip had an old pressure area. She stated it was a little smaller than a softball in size and was red, closed and blanchable. She stated his bilateral feet and heels had scabs on them and his feet were cool to touch. She stated there were pictures taken of the skin areas.</p> <p>On 4/3/24 at 11:15 AM, the Director of Nursing (DON) reported before Resident #1 went to the hospital he had a few different scattered areas on his feet. She stated Resident #1 would wear bunny boots in bed and did not want any other treatments to the areas on his feet. She stated he had scarred areas over the bony prominence on his right hip. She stated the pressure area on his right hip healed about a year ago. The DON reported she does not have any documentation regarding the areas to his feet as they were scattered scabbing. She stated she did not recall any ulcers to his heels. She reported she did not recall any skin areas to his bilateral groin.</p> <p>On 4/3/24 at 12:05 PM, Staff A, RN reported she rounded with the wound specialist on 3/28/24 and did not recall any areas to Resident #1's heels. She stated Resident #1 had some scabbed like areas to his toes on both feet. She described it as dead, dry built up skin. She stated Resident #1 would wear bunny boots all the time and would bump his toes.</p> <p>On 4/3/25 at 1:58 PM, the DON stated there was no particular reason Resident #1's skin areas on his feet were not documented in the medical record. She stated if a pressure ulcer was noted it would be measured and documented and the wound specialist would start monitoring the area. She stated non-pressure areas are monitored weekly on a non-pressure skin sheet. She stated she was aware that Resident #1 had areas to his right foot 2nd and 3rd toe. She stated there were not any pressure ulcers to his heels. She stated Resident #1 flopped his feet and sometimes banged his toes. She stated they had used betadine as a treatment in the past but that had been a long time ago.</p> <p>On 4/4/24 at 9:05 AM, Staff C, CNA reported Resident #1 had skin areas to both hips, lower legs and to his feet. She stated his right hip was red but not opened. She stated his feet were dry with flaky skin. She stated his right foot, tops of the toes, had scabbed areas. She stated Resident #1 would hit his toes on the dresser and he would not let the staff move the dresser. She stated he wore boots and had not had areas on his heels since wearing the boots.</p> <p>On 4/4/24 at 9:08 AM, Staff D, CNA reported Resident #1's feet were super dry. She stated she was a bath aide and would give Resident #1 bed baths. She stated she would lotion him up and apply baby oil to help with the dry skin. She stated she did not recall any skin areas to his heels as he wore bunny boots. When asked if he had scabbed areas to his feet, she said she did not think so. When shown the bath records for March she had signed, she stated she was not sure if she circled the right and left toes because of dry skin or if there were skin areas there. She stated she was not 100% sure about his toes.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's clinical record lacked documentation of pressure wounds to the right heel, left heel, and skin impairments/wounds to the right foot, left foot, right groin and left groin. The clinical record lacked documentation treatments had been offered to Resident #1 and/or the treatments had been refused. The clinical record lacked documentation of a preventative/protective treatment for the right hip after it was healed.</p> <p>Review of the Medication and Treatment Administration Record for March 2024 revealed lack of treatment orders for the right hip, right heel, left heel, right foot, left foot or bilateral groin areas.</p> <p>A facility policy titled Skin Evaluation dated 12/28/22 documented the facility may conduct head to toe skin evaluation and document on a weekly basis. The weekly skin evaluation will be documented electronically or on the skin observation tool. Any skin abnormalities identified through this evaluation may be documented in the interdisciplinary notes. The policy further directed that the Physician, resident representative, wound nurse and DON would be notified of any abnormalities and treatments would be initiated per the Physician's Order.</p> <p>A facility policy titled Wound Management dated 11/15/22 documented it was the facility policy to promote wound healing of various types of wounds and that the facility would provide evidence-based treatments in accordance with current Standards of Practice and Physician Orders. The policy further documented treatment selection will be based on the etiology of the wound.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>46875</p> <p>Based on the review of the Quality Assurance Performance Improvement (QAPI) sign in sheets, staff interview, and policy review, the facility failed to ensure all required members attended the quarterly Quality Assessment and Assurance (QAA) meetings. Specifically, the Director of Nursing (DON)/Infection Preventionist(IP) failed to be present for 2 of the 4 quarterly meetings reviewed. The facility reported a census of 45 residents.</p> <p>Findings include:</p> <p>Review of the QAPI meeting sign-in sheets from April 2023 to March 2024, provided by the Administrator on 4/2/24, revealed the DON/Infection Preventionist attended the meeting on 4/18/23 and 3/12/24.</p> <p>On 4/4/24 at 10:58 AM, the Administrator acknowledged and verified the QAPI sign in sheets lacked the DON/IP signatures except for the months of April 2023 and March 2024.</p> <p>The facility policy titled QAPI last reviewed on 8/20/20 documented the QAA will meet monthly and include the following team members: Administrator, DON, Medical Director, IP, Social Services Designee, Activities Director, Environmental Services, Dietary Manager, Medical Records, Human Resources, and Pharmacy.</p>		