STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165575	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER: Harmony Utica Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE: 3800 Commerce Blvd Davenport, IA 52807	

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observation, clinical record review, resident, family and staff interviews, the facility failed to provide a wound assessment and intervention for 1 of 3 residents reviewed (Resident #16). A bandage over a wound to the right buttocks on Resident #16 was identified by nursing staff on [DATE] without prior documentation and without provider notification for a treatment order. Resident #16 required hospitalization on [DATE] for sepsis, an infected wound, Methicillin-resistant Staphylococcus aureus (MRSA), Escherichia coli (E.coli) and a Urinary Tract Infection (UTI). Resident #16 expired on [DATE]. This deficient practice resulted in an Immediate Jeopardy to the health and safety of residents who resided at the facility. The facility identified a census of 89 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of [DATE] on [DATE] at 10:00 AM. The facility staff removed the Immediate Jeopardy on [DATE] by implementing the following actions: 1. Nurse education re-initiated on [DATE] to be completed 100% for all nurses prior to their next scheduled shift on skin practice guidelines that include direction on how to identify skin areas and wound care/dressing change, and Medical Director and family notification. 2. Baseline audit of skin on current patients in house on ,d+[DATE]//2024. 3. Nursing education on skin preventative measures including repositioning on [DATE]. The scope lowered from J to G at the time of the survey. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #16 revealed diagnoses of Parkinson's, anxiety and depression. The MDS listed the Brief Interview for Mental Status (BIMS) score as 15 out of 15 indicating intact cognition. The MDS revealed Resident #16 had limited Range of Motion (ROM) in both upper and lower extremity, and dependent upon staff for toileting, dressing and bed positioning. The MDS assessed the resident at risk for pressure ulcers, and lacked to identify a pressure ulcer yet identified an application of a non-surgical dressing. The Care Plan for Resident #16 directed staff to encourage frequent repositioning, use assistive devices as needed and administer treatment as per the physician orders. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:43 p.m., Resident #16's daughter stated she had seen her mother on [DATE] and Staff D, Licensed Practical Nurse (LPN) applied a dressing to her mother's right buttocks. When she asked to see it, the nurse informed her it was just a surface wound. The daughter stated a week later, she received a call from Staff F, LPN who stated the wound needed to be seen by the wound nurse, then a week later her mother needed to be seen at a wound clinic. The daughter stated she called the wound clinic and reported to the facility that the earliest appointment was in a week. During a visit on [DATE], staff informed the daughter, Resident #16's blood pressure was low, she had been feeling sick but it was due to waxing of floor and they moved her to a different room. The daughter stated the facility called her on [DATE] to ask if her mother could be treated at the hospital, I said yes absolutely. The daughter said the emergency room physician showed her the wound was a 5 centimeter, tunneling, infected wound and transferred her mother to the intensive care unit for 4 days. The Treatment Administration Record dated [DATE] documented the following treatment orders: a. Right gluteal crease - cleanse with Normal Saline (NS), apply xeroform and cover with a foam dressing 3 x weekly and as needed (PRN) every day shift on Tuesday, Thursday and Saturday for wound care. With an order start date of [DATE], and discontinuation date of [DATE]. c. Right buttock- cleanse with NS, apply slightly moistened Hydrofera Blue (wound product to provide protection and address bacteria and yeast), cover with foam dressing every day shift, every other day for wound care. With an order start date of [DATE], and discontinuation date of [DATE]. A review of Progress Notes for Resident #16 revealed: a. Lack of documentation on [DATE] of a wound. b. On [DATE] at 2 p.m. An open area to the right buttocks measured 4.5 cm x 3 cm x 0.5 cm and the left inner gluteal cleft measuring 3 cm x 2 cm x 0.1 cm. c. Resident had no pain, no drainage, the site was cleansed, xeroform and foam applied. d. The wound nurse was notified. e. The doctor and the Power of Attorney (POA) were notified. A review of the clinical record revealed documentation for Resident #16 by the Certified Nursing Assistant (CNA) staff, dated [DATE] thorough [DATE], titled Positioning Resident Offered or Repositioned within every 2 hours. The documentation lacked entries for multiple shifts. During an interview on [DATE] at 2:19 PM, Staff E, CNA, stated she had worked in the facility for three years, and received direction for each resident Care Plan and documented in the electronic health record when she turned and repositioned a resident. Staff E stated when she visualized a wound, she would report it to the nurse. Staff E stated she had found Band-Aids on resident's that no one knows about, they are just there. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 7:22 AM. Staff F, LPN stated she had worked in the facility for [AGE] years. Staff F stated she had found Band-Aids or foam dressings on residents without documentation multiple times. Staff F stated she found the dressing to Resident #16's right buttocks and did not see the wound on [DATE] when she applied a dressing to the wound below it. It's frustrating, it doesn't take much to document it and get a treatment. Staff F stated she reported the new wound on [DATE] to the physician, POA and the wound nurse. During an interview on [DATE] at 3:56 PM. Staff G, CNA stated she remembered Resident #16's bed sore and assisted her to turn so Staff D could treat it. Staff G stated, That same exact day she (Resident #16) started a temperature and she said she was cold. The facility provided a document titled Harmony Statement which involved Resident #16 that revealed: a. Person interviewed was Staff D, Licensed Practical Nurse (LPN) b. Person conducting interview was the Director of Nursing (DON) c. Date of incident [DATE] d. Date of interview [DATE] e. On [DATE] at 5:15 PM., a skin assessment was completed. The daughter was at bedside. All open areas treated per physician orders, no new open areas were noted. f. Signed by Staff D, LPN on [DATE] and the DON. The facility provided a document titled Harmony Statement which involved Resident #16 that revealed: a. Person interviewed was Staff F, LPN. b. Person conducting the interview is not identified. c. Date of incident [DATE] d. Date of interview [DATE] e. On [DATE], Staff F stated she went in to do the a left ischial (bony area on bottom of pelvis, often called a sit bone) treatment for Resident #16 and found a foam dressing on Resident #16's right buttocks. The wound was measured, completed skin sheet, notified provider, and obtained an order. Staff F notified the daughter and wound nurse. Staff F stated she did not recall previous skin assessments or noticing this area. f. Signed by Staff F, LPN and the DON. A review of documents referred to as skin sheets for Resident #16 related to the right gluteal crease revealed: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Initial observation on [DATE] lacked documentation. b. [DATE] measurement 1.5 cm x 1.0 cm x 0.1 cm, partial thickness, surrounding skin reddened. New order for Xeroform dressing, change 3 times a week and as needed (PRN). c. [DATE] measurement 2.4 cm x 1 cm skin intact, reddened, and continued the treatment. d. [DATE] measurement 2.4 cm x 1 cm x 0.1 cm partial thickness, reddened and excoriated. e. [DATE] lacked an assessment. f. [DATE] measurement 3 cm x 1.2 cm normal for skin, and continued the treatment. g. [DATE] measurement 3 cm x 1 cm pink, pale tissue, and continued the treatment. h. [DATE] the wound was resolved. A review of skin sheets for Resident #16 right buttocks area revealed: a. Initial observation on [DATE] measurement 4.5 cm x 3 cm x 0.5 cm partial thickness, wound bed had slough (moist yellow or gray necrotic tissue), and a treatment order for Xeroform. b. [DATE] measurement 4.5 cm x 3.1 cm x 0.4 cm partial thickness, and the wound bed had slough. During an interview on [DATE] at 10:09 AM Staff H, Wound Nurse, stated she had assessed a wound for Resident #16 on [DATE] right buttocks that was unstageable due to slough, and it had an odor that resolved after cleaning with normal saline. Staff H described 2 small wounds with skin between and she measured it together as 1 wound. Staff H stated on [DATE] the wound was larger, with an odor that did not resolve with cleaning, therefore she notified Resident #16's daughter as she needed an appointment with the wound clinic. Staff H stated she was unaware that the wound clinic appointment was scheduled for a week later. During an interview on [DATE] at 11:43 a.m. Staff D, LPN stated he is an agency nurse serving the facility for 3 years and had met Resident #16 a few times. Staff D stated on [DATE] Resident #16's daughter was present in the room when he placed a treatment to her right bottom. Staff D stated the daughter asked about the need for the wound clinic, and he reported it's not bad and not for me to decide and the wound nurse see's people there. Staff D stated the wound was pink, smaller than a quarter, cleaned it, placed Xeroform (type of gauze dressing) on it and checked it off in the TAR. Staff D stated he did not remember documenting it. A hospital document titled ED Triage Notes dated [DATE] revealed: a. Patient presented with Altered Mental Status (AMS), diagnosed with UTI, started antibiotic, facility admits to some fevers and increased confusion and tachycardia (fast heart rate). b. No Tylenol or ibuprofen given for fever 101.8 before arrival. c. Oxygen saturation (oxygen in blood) 88% (normal ,d+[DATE]%) placed on 2 liters of oxygen. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Admit diagnosis Infected pressure ulcer, Stage IV, septic shock, UTI with indwelling catheter, elevated lactic acid level and hypotension (low blood pressure). e. Critical lab values, admitted to ICU for heart monitoring, hypotension and sepsis. A Hospital document titled Wound Care Initial Consultation Note dated [DATE] for Resident #16 revealed: a. Evaluation of complex wound/ulcer. b. admitted on [DATE] for Sepsis. c. Right ischial ulcer, unstageable, boggy to touch, drained a large amount of dark purulent (thick milky or yellows fluid) foul odorous drainage, and measured 4.5 cm x 5 cm x 1.5 cm. d. Wound culture was obtained. e. Left ischial, Stage 3 pressure ulcer, scant amount of serosanguineous (blood with serum) drainage, measured 1.5 cm x 2 cm x 0.1 cm. f. Treatment order. g. Follow up with the wound center upon discharge. During an interview on [DATE] at 8:12 AM, the DON stated she expected nursing staff to make weekly assessments of wounds, follow physician orders when treating wounds, turn and reposition residents frequently. The State of Iowa Certificate of Death for Resident #16 dated [DATE] revealed the immediate cause of death was due to non-healing pressure ulcerations.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44512 Based on observation, clinical record review, policy review, and resident and staff interview the facility failed to complete nursing assessments and monitoring of a resident before and after outpatient dialysis for 1 of 1 resident reviewed (Resident #72). The facility reported a census of 89 residents. Findings include: The Minimum Data Set (MDS) for Resident #72, dated 4/17/24, listed diagnoses of end stage renal disease, and type 2 diabetes mellitus with diabetic chronic kidney disease. The MDS listed the Brief Interview for Mental Status (BIMS) with a score of 15 indicating no cognitive impairments. The MDS revealed Resident # 72 received dialysis. The Care Pan for Resident # 72 directed staff to check the fistula (a connection that's made between an artery and a vein for dialysis access) daily, identified the potential for bruising and hemorrhage due to anticoagulant (medication to keep blood from clotting) use. The Care Pan lacked direction for the nursing staff to provide an assessment for the resident before and after dialysis therapy. During an observation on 6/10/24 at 2:41PM, Resident #72 had dark purple/blue bruising on her right upper arm just below the fistula. During an interview on 6/10/24 at 2:41PM, Resident #72 stated the nursing staff assessed her blood pressure before dialysis but not every time she returns from dialysis due to busy lunch time. A review of Physician Orders revealed: a. An ordered dated 4/17/23 to Check fistula on the right upper extremity for positive (+) bruit (whooshing sound) and + thrill (vibration caused by blood flowing through the fistula) every shift. Notify the physician of any redness, swelling or drainage, assessment every shift. b. An ordered dated 7/4/23 for Dialysis PRE/ POST [before and after dialysis] vitals to be obtained by nurse for assessment, two times a day every Tuesday, Thursday, and Saturday for monitoring. The Treatment Administration Record (TAR) dated May 2024 lacked documentation for a pre-dialysis assessment on 5/2/24 and 5/16/24; a post dialysis assessment on 5/9/24, 5/18/24, and 5/25/24; and a fistula shift assessment on 5/2/24 and 5/25/24. The TAR dated June 2024 lacked documentation for a pre-dialysis assessment on 6/11/24; a post dialysis assessment on 6/4/24; and a fistula shift assessment on 6/1/24. During an interview on 6/13/24 at 8:12 AM, the Director of Nursing (DON) stated her expectation was when providing care for a dialysis resident was to provide an assessment which included vitals 30 minutes to an hour before going to dialysis, provide medication and meals, then follow through with a post dialysis assessment when the resident returns from dialysis. She stated the fistula should be assessed daily or as the physician orders, and in this case, it was every shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated facility policy, titled Focus on F Tag 698 revealed a lack of direction for nursing staff to complete a pre- dialysis assessment. The policy directed staff to complete a post dialysis assessment and site observations.