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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>165586 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>08/01/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Timely Mission Nursing Home |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>109 Mission Drive<br>Buffalo Center, IA 50424 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| <p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Assess the resident when there is a significant change in condition</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</b></p> <p>Based on record review, staff interview, and Resident Assessment Instrument (RAI) Manual the facility failed to ensure 2 of 2 residents (Resident #20 and #19) Significant Change Minimum Data Set (MDS) assessments were completed within 14 days of identifying a significant change occurred. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>1. Record review of Resident #20 revealed a Physicians Order documented the resident was discharged from hospice on 11/22/23.</p> <p>Record review of Resident #20 revealed that a Significant Change MDS was not completed when the resident had been discharged from hospice care.</p> <p>During an interview on 7/30/24 at 1:21 PM, the MDS Coordinator reported when a resident goes on or off hospice she has not done anything for MDS completion for it. She reports the facility follows the RAI Manual.</p> <p>During an interview on 7/30/24 at 2:08 PM, the Director of Nursing reports the facility does not have a policy for MDS. She reports the facility follows the RAI Manual.</p> <p>Review of the current RAI Manual dated 10/2023 on page 2-25 instructed the following:</p> <p>A Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Significant Change MDS date must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A Significant Change MDS must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>46875</p> <p>2. Resident #19's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition.</p> <p>Review of clinical census revealed Resident #19 was admitted to hospice level of care on 11/30/23.</p> <p>Review of the clinical record revealed the facility did not complete a significant change MDS within 14 days of Resident #19 being admitted to hospice services. The facility completed an annual assessment with an ARD date of 12/28/23 on 1/11/24.</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>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</b></p> <p>Based on clinical record review, staff interviews, resident interview and policy review the facility failed to assure that a resident with a pressure ulcer received treatment and services, consistent with professional standards of practice, to promote healing of two stage two pressure ulcers for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 30 residents.</p> <p>Finding 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>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 assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS identified Resident #1 required partial/moderate assistance with sitting up and lying down in bed. The MDS identified Resident #1 was independent with transfers and ambulation 150 feet using a walker. The MDS revealed Resident #1 was occasionally incontinent of bowel and bladder. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, and anxiety disorder. The MDS indicated Resident #1 was not at risk for developing pressure ulcers. The MDS documented Resident #1 had a pressure reducing device for the bed.</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>An Incident Report (IR) titled New Pressure Ulcer dated 7/9/24 documented Resident #1 complained of pain to the right buttocks. Upon examination the right inner gluteal was noted to have an open area that measured 0.5 cm (centimeters) x 0.3 cm. No bleeding noted to the open area. The IR revealed Resident #1 sat in her recliner a lot during the day and frequently did not get the right buttocks cleaned after having a bowel movement. The IR lacked documentation of a new intervention to prevent further skin breakdown/pressure areas.</p> <p>The Care Plan revised 7/29/24 revealed Resident #1 had a pressure ulcer on her buttocks related to not wanting to reposition. The Care Plan directed the following:</p> <ol style="list-style-type: none"> <li>a. Administer treatments as order and monitor effectiveness.</li> <li>b. Assess/record/monitor wound healing weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing process. Report improvements and declines to the Physician.</li> <li>c. Encourage Resident #1 to reposition.</li> <li>d. Monitor during AM/HS cares dressing to ensure it is intact and adhering. Report loose dressing to the charge nurse.</li> <li>e. Monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size and stage.</li> </ol> <p>Resident #1's Care Plan lacked information regarding pressure reducing devices to the bed or chair related to immobility and nutritional supplements to aid in wound healing.</p> <p>Review of Resident #1's Kardex lacked information and direction regarding skin and pressure reduction interventions such as chair cushion, repositioning, and encouraging Resident #1 to get up and walk.</p> <p>The Braden Scale assessments (tool used to evaluate risk of development of a pressure ulcer) documented a score of 10-12 indicated that the resident had a high risk for pressure sore development, 13-14 meant the resident had a moderate risk, and 15-18 meant the resident had a risk for pressure ulcer development. The review of the Braden Scale assessments completed for Resident #1 from 4/2024 to 7/2024 documented scores on the following dates:</p> <ol style="list-style-type: none"> <li>1. 7/7/24= 21</li> <li>2. 4/19/24=21</li> </ol> <p>Resident #1's clinical records lacked a Braden Scale assessment after the development of the stage 2 pressure ulcer.</p> <p>A facility form titled Wound-Weekly Observation Tool dated 7/10/24 documented Resident #1 had a stage two pressure ulcer to the right inner gluteal. The observation tool documented the area was cleansed with normal saline and a barrier cream applied. The form revealed the facility was waiting for further orders from the Physician.</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 Progress Notes/Communication with the Physician dated 7/10/24 documented Resident #1 had an open area to the right inner gluteal measuring 0.5 cm x 0.3 cm. The area was cleaned and barrier cream applied. The note revealed Resident #1 sat on a cushion while in her recliner. The note documented Resident #1 frequently did not clean herself well following having a bowel movement and sat in her recliner for long periods of time to play her tablet. The Physician responded that the treatment would be for Resident #1 not to sit for long periods of time but that won't happen. The Physician did not provide/direct a treatment order for the pressure wound to the right buttocks.</p> <p>A Progress Note dated 7/10/24 at 10:56 AM documented fax received from the Physician regarding open area to right inner gluteal with no new orders.</p> <p>A Progress Note dated 7/11/24 at 1:31 AM documented Resident #1 continued to complain of discomfort to the right inner gluteal. The pressure area had redness and barrier cream applied.</p> <p>A Progress Note titled Skin/Wound note dated 7/11/24 at 5:17 PM documented a stage two pressure ulcer remained to the right buttock. Resident #1 reported discomfort to the area if she sat the wrong way. The note revealed the pressure ulcer was cleansed, Vaseline applied and a padded foam dressing was applied. Resident #1 reported the dressing helped a little bit. The note documented Resident #1 was educated if the dressing falls off during toileting to use the call light so the area could be redressed. The clinical record lacked a Physician order for the treatment of Vaseline and foam dressing to the pressure ulcer on the right buttocks.</p> <p>A Progress Note titled Nutrition/Dietary note dated 7/12/24 at 11:57 AM documented Resident #1 had a stage two pressure wound to the buttocks. The note documented Resident #1 does eat well with meals but may benefit from Arginaid (nutritional supplement used for wound healing) to assist with wound healing. Review of the clinical record revealed the dietary recommendation for Arginaid was not communicated to the Physician and was not started.</p> <p>A Progress Note dated 7/17/24 at 6:34 AM documented a fax was sent to the Physician requesting a treatment order for Resident #1's pressure area to the right buttocks as the area had not improved.</p> <p>A Progress Note dated 7/17/24 at 1:23 PM documented a fax was received with new order to apply sorbact dressing (non-absorbent wound dressing) to the pressure ulcer to right upper buttocks and to change the dressing every two days and as needed for non-adherence.</p> <p>A Progress Note dated 7/20/24 at 3:53 PM documented Resident #1 had her dressing changed to the right upper buttocks due to complaints of pain. The note revealed Resident #1 had a new stage two pressure ulcer to the lower coccyx and a dressing was applied to the new area. The note indicated Resident #1 had relief with the new dressing change. The progress note lacked documentation regarding the size of the new pressure ulcer and characteristics of the wound.</p> <p>A facility form titled Wound-Weekly observation tool dated 7/20/24 documented Resident #1 had a stage two pressure ulcer to the lower left coccyx. The tool revealed the wound was dry without any drainage. The assessment lacked documentation regarding the measurements/size of the wound, wound bed tissue, odor, periwound tissue and signs/symptoms of inflammation or infection.</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 7/20/24 at 3:54 PM documented a fax was sent to the Physician reporting a new stage two pressure ulcer to the lower coccyx on the left side. The note documented the facility requested a treatment order for sorbact dressing and to cover the area with a foam dressing.</p> <p>The Clinical Record lacked documentation Resident #1's family/resident representative was notified of the new pressure area from 7/20/24.</p> <p>A Progress Note dated 7/22/24 at 9:28 AM documented a fax was received with a new treatment order to apply sorbact dressing to the left side of coccyx and to change the dressing every 7 days and as needed if soiled, saturated, or falls off prior to schedule dressing change. The clinical record lacked documentation Resident #1's family/resident representative was notified of the new treatment orders.</p> <p>A Progress Note dated 7/22/24 at 5:33 PM documented Resident #1 continued to have an open area to coccyx and a new pad was placed in Resident #1's recliner. The note documented staff continued to encourage repositioning and walking in the hallway.</p> <p>Review of facility forms titled Wound-Weekly Observation Tool for Resident #1's pressure ulcer to the right buttocks revealed the pressure ulcer was measured on 7/10/24. The clinical record and wound-weekly observations tools lacked wound measurements after 7/10/24.</p> <p>The clinical record and the facility forms titled Wound-Weekly Observation Tool for Resident #1's pressure ulcer to the left side of the coccyx lacked wound measurements from 7/20/24 to 7/31/24.</p> <p>On 7/29/24 at 1:21 PM, Resident #1 reported she had a sore on her bottom and it was painful. Resident #1 reported she does not like the cushion in her recliner. She stated the cushion makes the sore on her bottom hurt more.</p> <p>On 7/30/24 at 10:40, Staff A, Licensed Practical Nurse (LPN) reported wounds are measured on bath days and documented either on the wound data collection form or in the skin/wound notes.</p> <p>On 7/30/24 at 10:30 AM, the Director of Nursing (DON) reported an Incident Report was not completed for the pressure ulcer on 7/20/24.</p> <p>On 7/30/24 at 12:50 PM, the DON reported Resident #1 had a chair cushion in place at the time the pressure ulcer to the right buttocks was identified. The DON reported the new skin interventions were for the staff to encourage Resident #1 to get up and walk and encourage Resident #1 to walk to breakfast. The DON reported a barrier cream was applied to the pressure area when it was first identified. The DON reported when the second pressure ulcer developed on 7/20/24 she gave Resident #1 a new air cushion but she did not think she documented it. The DON reported she would expect a physician order to be obtained for any wound treatments.</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>On 7/30/24 at 1:28 PM, the DON acknowledged and verified she could not locate any wound measurements for the pressure ulcer to the right buttocks after 7/10/24. The DON also verified she could not locate any wound measurements for the pressure ulcer to the left lower coccyx. The DON stated she would expect pressure ulcers to be measured upon identification and weekly thereafter. The DON reported she would expect the Physician to be notified of any changes in the pressure ulcer. The DON acknowledged and verified she could not locate any family notification regarding the pressure ulcer to the left lower coccyx and the treatment order. The DON reported she had missed the email from the dietician regarding the recommendation for Arginaid and verified the recommendations were not followed up on.</p> <p>On 7/31/24 at 8:00 AM, Staff A, LPN reported Resident #1 does not come out for breakfast. She stated she had worked at the facility for 5 years and has not seen Resident #1 out at breakfast. She stated she eats breakfast in her room and comes out to the dining room for lunch and supper.</p> <p>On 7/31/24 at 9:24 AM, Staff B, Certified Nursing Assistant (CNA) stated she did not recall anything being passed in report about the need to encourage Resident #1 to get up and walk more or reposition more due to pressure ulcers.</p> <p>A facility policy titled Skin Integrity date 4/20 documented the policy was to ensure the resident does not develop pressure ulcers/injuries unless clinically unavoidable and that the facility provide care and services consistent with professional standards. The policy documented the facility must:</p> <p>*Identify whether the resident is at risk for developing or has a pressure ulcer/injury upon admission and thereafter</p> <p>*Evaluate resident specific risk factor and changes in the resident ' s condition that may impact the development and/or healing of the pressure ulcer/injury</p> <p>*Implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors and if pressure ulcer/injury present, provide treatment to heal it and prevent the development of additional pressure ulcers/injuries.</p> <p>The policy further documented clinicians will utilize a standardized pressure ulcer/injury risk assessment tool (i.e.braden) to assess a resident ' s pressure ulcer/injury risks:</p> <ul style="list-style-type: none"> <li>-Upon admission then,</li> <li>-Weekly for the first four weeks after admission, then</li> <li>-Monthly and</li> <li>-Whenever there is a change in resident ' s condition</li> </ul> <p>Clinicians are responsible for evaluating each existing and potential risk factor for developing a pressure injury and determining the resident ' s overall risk. It is acceptable if the clinician ' s assessment places the resident at a higher risk level than the overall score of the assessment tool based on assessment factors that are not captured by the tool.</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>The policy documented all goals and interventions to prevent pressure ulcer/injury development as well as treatment to promote healing, prevent infection and the development of new ulcers/injuries will be included in the resident ' s comprehensive care plan developed by the interdisciplinary team following comprehensive assessment.</p> <p>The policy directed with each dressing change or at least weekly (and more often when indicated by wound complication or changes in wound characteristics), an evaluation of the pressure ulcer/injury should be documented. At a minimum, documentation should include the date observed and:</p> <ul style="list-style-type: none"> <li>-Location and staging</li> <li>-Size, depth, and the presence, location and extent of any undermining or tunneling/sinus tract</li> <li>-Exudate, if present: type, color, odor, and approximate amount</li> <li>-Pain, if present: nature and frequency</li> <li>-Wound bed: color and type of tissue/character including evidence of healing, or necrosis and</li> <li>-Description of wound edges and surrounding tissue as appropriate.</li> </ul> <p>-If a pressure ulcer/injury failed to show some evidence of progress toward healing within 2-4 weeks, the area and the resident ' s overall clinical condition should be reassessed. Re-evaluation of the treatment plan included determining whether to continue or modify the current interventions. The resident ' s physician must be notified/consulted regarding the status of the pressure ulcer/injury and prescribe treatment going forward, if appropriate.</p> <p>-Residents will be assessed for evidence of pain and appropriate measures and modifications be provided to relieve and/or diminish pain.</p> |  |  |