STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165621	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of Cedar Rapids	5710 Dean Road SW Cedar Rapids, IA 52404

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. 25854 Based on observation, clinical record review, and staff interview, the facility failed to provide interventions/treatments for 1 of 3 residents with skin breakdown (Resident #3) and the facility failed to obtain physician's orders for 1 of 3 residents reviewed (Resident #3). The facility identified a census of 36 residents. Findings include: Provider Progress Notes form dated 7.17.24 at 8:02 a.m. thru 7.19.24 at 9:02 a.m. indicated Resident #3 had active diagnoses that included Lymphedema of both lower extremities, a stage III pressure ulcer to her right thigh, venous stasis ulcers to her bilateral lower legs dated 7.15.24, a non pressure injury to the residents right foot, and an infestation of maggots to the resident's left extremity wounds. The form also included photos and measurements of all of the resident's wounds for the facility nurse's to have reviewed and addressed accordingly. The recommendations for care and treatment included the following: a. Triad Wound Paste cream to the coccyx, sacrum, posterior thighs, medial thighs, right lateral thigh, deep tissue injury, left breast wound, right abdominal wound, gluteal cleft and buttocks 3 times a day (TID) and as needed (PRN) for incontinence. b. Elevated heels off the bed surface. c. Repositioned every two (2) hours. d. Bariatric low air loss to bed surface. e. Avoidance of the use of incontinence briefs when in bed and at night. f. Miconazole cream to breast folds, groin folds, pannus folds, posterior knee folds, gluteal cleft, posterior and medial thighs 2 times a day (BID) for 14 days. f. Right dorsal foot to have cleansed with saline, pat dry, covered wound bed with a silicone bordered foam dressing to have been changed every other day (EOD) and PRN. (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	g. The right and left circumferential legs, venous to have been cleansed with saline, pat dried, cut plan foam to have been 2 centimeters (cm) larger than the wound base on all sides and applied. Secured with Kerlix and tape and changed QD and PRN. A facilities Admit/Readmit Screen form signed 7.25.24 contained the following skin/wound assessments: a. Right buttock pressure area that measured 6.0 centimeters (cm) by (x) 8.0 cm x 0.2 cm deep. b. Right rear thigh unstageable pressure area that measured 9.5 cm x 8.0 cm x 0.2 cm. c. Right lower extremity (RLE) stage III area on her calf that measured 18.0 cm x 28.0 cm x 0.3 cm. e. Left lower extremity (LLE) stage III area on her calf that measured 20.0 cm x 32.0 cm x 0.3 cm. f. Right gluteal fold stage II pressure area that measured 2.0 cm x 2.0 cm x 1.0 cm. g. A coccyx pressure area (not staged) that measured 3.0 cm x 2.0 cm x 0.2 cm. h. The groin, abdominal, and chest areas with moisture associated skin damage (MASD) not measured. i. Right anterior foot stage II area that measured 0.8 cm x 1.0 cm x 0.1 cm. Review of a Medication Administration Record (MAR) and Treatment Administration Record (TAR) form dated 7.1.24 thru 7.31.24 revealed no physician treatment orders from 7.24.24 thru 7.28.24. A Fax form dated 7.25.24 contained the following documentation: Resident admitted 7.24.24 with the following skin issues: a. Right buttock, stage II area that measured 6.0 cm x 8.0 cm x 0.2 cm deep. b. Right thigh unstageable pressure area that measured 9.5 cm x 8.0 cm x 0.2 cm. c. Right lower extremity, stage III pressure ulcer that measured 18.0 cm x 28.0 cm x 0.3 cm. d. Left lower extremity, stage III pressure ulcer that measured 20.0 cm x 32.0 cm x 0.3 cm. f. Right gluteal fold, stage II 2.0 cm x 2.0 cm x 1.0 cm. g. Coccyx pressure area (not staged) that measured 3.0 cm x 2.0 cm x 0.2 cm. h. Groin, abdomen and chest area with MASD. j. Right anterior foot, stage II that measured 0.8 cm x 1.0 cm x 0.1 cm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Verbal order form dated 7.24.24 at 4:37 a.m. included the following physician order: Triad Hydrophilic Wound Dressing External Paste (wound dressing) applied to coccyx, buttocks topically every morning and at bedtime for the wounds after staff cleansed the affected areas thoroughly with soap and water, rinsed and dried well. Application of the ointment should have occurred to all areas of rash rubbing in well to one inch past areas of redness confirmed by the Director of Nursing (DON). A separate Verbal order form dated 7.24.24 at 4:37 a.m. included the following physician order: Micatin Cream 2% applied to affected area topically BID for a wound (area not specified). During an interview 8.16.24 at 8:30 a.m. the Interim Administrator confirmed on 7.28.24 at approximately 7 p. m. Staff A, Licensed Practical Nurse (LPN informed her via a telephone call that she had been unable to locate treatment orders on the resident's MAR and TAR for this resident admitted with multiple skin wounds/ulcerated areas. The Interim Administrator then called the DON who indicated she faxed the admission measurements of the wounds to the Physician on 7.25.24 but she had been pulled to work as a nurse on the floor so she inadvertently forgot to follow up with the Physician as a means to obtain treatment orders as expected. During an interview 8.16.24 at 10:17 a.m. the DON confirmed the resident admitted to the facility on 7.24.24 as Staff B, LPN /Admission and Wound Care Nurse performed the admission assessment and addressed all of the resident's wounds/ulcerated areas. On 7.25.24 when the DON arrived to work she noted no wound treatment orders had been addressed on the TAR so she faxed the Physician for orders. Also note, Verbal orders dated 7.24.24 at 4:37 a.m. for treatments that were not placed on the MAR/TAR until 7.29.24. The DON had originally been unable to explain why the Physician orders had not been transcribed onto the MAR/TAR. At 10:30 a.m. the DON then confirmed on 8.1.24 she had backdated the above documented orders because that had been when the Physician orders should have been initiated and performed by the nursing staff. During an interview 8.16.24 at 10:40 a.m. Staff C, RN/Corporate Nurse Consultant and the Administrator confirmed they expected any nurse who cared for this resident to have obtained Physician orders for the resident's wounds which had been a nursing standard of practice and an expectation of the facility management team.