STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165793	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Summit of Bettendorf	4699 53rd Avenue Bettendorf, IA 52722

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821 Based on observation, clinical record review, staff interview and facility policy review the facility failed to notify the Ombudsman's office three out of three times one resident went to the hospital (Resident #7). Findings include: Resident #7's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of heart failure, urinary tract infection (UTI) and renal (kidney) failure. The MDS Tracking for Resident #7 listed discharges to the hospital occurred on 10/27/23, 12/9/23 and 2/28/24. The Ombudsman Notification list provided by the facility for the months of October 2023, December 2023, and February 2024 failed to reflect Resident #7's discharged to the hospital on 10/27/23, 12/9/23 and 2/28/24. On 3/21/24 at 1:34 PM, the Administrator reported the Social Service department staff are responsible for the notification to the Ombudsmen of a discharged resident. He confirmed the Social Service department failed to know that needed done for long term residents. The Discharge/Transfer of the Resident policy dated January 2023, directed the staff to complete Notice of Transfer form to Long term Care Ombudsman.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165793	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821 Based on observation, clinical record review, staff interviews and facility policy review the facility failed to provide a Bed Hold Notice to 3 out of 3 residents reviewed for hospitalization (Residents #7, #9, and #14). Findings include: 1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of heart failure, urinary tract infection (UTI) and renal (kidney) failure. The MDS Tracking for Resident #7 listed discharges to the hospital occurred on 10/27/23, 12/9/23 and 2/28/24. Resident#7's Progress Note dated 10/27/23, 12/9/23 and 2/28/24 failed to reflect the facility provided the Bed Hold Notice. On 3/20/24 at 2:05 PM, Resident #7 sat at the dining room (DR) table as other residents played a card game. On 3/21/24 at 1:29 PM, the Administrator and Staff B, Registered Nurse Consultant (RNC), confirmed they expected the floor nurses to offer a Bed hold to the resident and/or family when they send a resident to the hospital. Afterwards, they need to communicate that with the Social Services staff. The Administrator confirmed he expected the nurses to document the Bed Hold provided in the progress notes. The Bed Hold Policy dated October 2022 instructed the Skilled Nursing Facility/Nursing Facility (SNF/NF) communities develop and implement policies that address permitting residents to return to the community after a hospitalization or therapeutic leave. Specifically, residents who are hospitalized or on therapeutic leave are allowed to return to the community for skilled nursing or nursing community care or services. 25855 2. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified BIMS score of 15, indicating intact cognition. The MDS included diagnoses of pneumonia, renal insufficiency (kidney failure) and osteoporosis (fragile bones). The MDS Tracking reflected Resident #9 transferred to the hospital on 3/13/24. Resident #9's Progress Note dated 3/13/24 failed to include documentation the facility provided the Bed Hold Notice within 24 hours of being transferred to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9's Progress Note dated 3/18/24 at 1:50 PM documented he returned from the hospital with a prescription for Augmentin (an antibiotic) to treat a diagnosis of Pneumonia. In an interview on 3/18/24 11:50 AM, Staff C, Certified Nurse Aide (CNA)/ Certified Medication Aide (CMA) reported Resident #9's location as the hospital. In an observation on 3/18/24 at 1:38 PM, Resident #9 sat in a recliner in his room, wearing a neck brace, properly positioned and appeared comfortable. He stated he stayed in the hospital for the past week with a high temperature and a low blood pressure. 3. Resident #14's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS (Brief Interview for Mental Status) score of 14, indicating intact cognition. The MDS included diagnoses of a fracture to the right arm, atrial fibrillation (an abnormal heart rhythm), and diabetes mellitus. The MDS Tracking for Resident #14 failed to include the hospital transfer on 1/30/24. The progress note dated 1/30/24 at 10:39 AM had documented Resident #14 went to the Emergency Department (ED). The progress note lacked the facility offered a Bed Hold Notice to Resident #14 within 24 hours of being transferred to the hospital. Resident #14's Progress Note dated 2/1/24 at 4:54 PM indicated Resident #14 returned to the facility with a diagnosis of uncontrolled pain related to a fracture to the humerus (a broken bone to the arm). In an observation on 3/18/24 at 11:51 AM, Resident #14 sat in her power chair in the dining room with a wound vac in place and suctioning properly. In addition, Resident #14 had her right arm in a sling elevated on a pillow while wearing Prafo boots (specialized pressure relieving boots) with compression wraps to both legs and feet.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, staff interview, and record review, the facility failed to administer insulin as directed by the Physician Order. The nurse failed to prime an insulin pen for 2 of 2 doses for 1 resident observed during medication administration (Resident #25). Findings include: Resident #25's Minimum Data Set (MDS) assessment dated [DATE] identified Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. The MDS included diagnoses of cancer, septicemia (blood poisoning by bacteria) and diabetes mellitus. Resident #25 required total dependence from staff with transferring in the bed, out of the bed, and toilet use. The physician order dated 2/24/24 documented, Insulin Lispro (rapid acting insulin) Injection 100 units per ml (milliliter) Inject as per sliding scale before meals: 70 99 = 6 Units; 100 160 = 7 Units; 151 180=8 Units; 181 210=9 units; 211 240=10 Units; 241 270=11 Units; 271 300=12 Units; 301 330=13 Units; 331 360=14 Units; 361 390=15 Units; 391 420=16 Units; 421 450=17 Units; Inject subcutaneously before meals. The physician order dated 2/24/24 listed Insulin Glargine (slow acting insulin) 100 units per ml. Inject 22 units subcutaneously in the morning. During an observation on 3/19/24 at 8:06 AM, Staff D, RN (Registered Nurse), without priming the insulin pen needles, administered Lispro 15 units and Glargine 22 units into Resident #25's abdomen. The Care Plan dated 2/27/24 identified Resident #25 had Diabetes Mellitus and directed the staff to: a. Administer diabetes medication as ordered by doctor. b. Monitor/document for side effects and effectiveness. c. Monitor blood sugar levels as ordered and report to physician as warrants. Resident #25's March 2024 Medication Administration Record (MAR) included the following orders: a. Start date 2/24/24: Insulin Glargine 100 units per milliliter (ml). Inject 22 units subcutaneously in the morning. - signed as given on 3/19/24. b. Start date 2/24/24: Insulin Lispro Injection 100 units per ml. Inject as per sliding scale before meals: 361 390 = 15 Units. Inject subcutaneously before meals. - signed as given on 3/19/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Start date 3/19/24: Insulin Glargine 100 units per ml. Inject 2 units subcutaneously one time only for blood glucose of 526. - signed as given on 3/19/24 at 10:15 AM d. Start date 3/19/24: Insulin Lispro Injection 100 units per ml. Inject 2 units subcutaneously one time only for blood glucose of 526. - signed as given on 3/19/24 at 10:15 AM. The Nurses Note dated 3/19/24 at 9:51 AM indicated Resident #25's Dexcom (continuous glucose monitor) reflected a HIGH reading. When the nurse checked her blood sugar by completing a finger stick, her blood glucose level read 526. The nurse notified the provider who gave orders to give 2 units of Lispro and 2 units of Glargine at that time, then recheck her glucose level in 30 minutes. The Nurses Note dated 3/19/24 at 10:15 AM indicated the nurse administered 2 units of Glargine and 2 units of Lispro as ordered. The nurse reported to the oncoming nurse to recheck her blood glucose level in 30 minutes and notify the provider of the results. The Nurses Note dated 3/19/24 at 10:21 AM reflected the nurse notified Resident #25's family member her condition and blood glucose levels at that time. The progress notes lacked the order to recheck the blood glucose levels at 10:20 AM and 10:45 AM. The Blood Sugar Summary reviewed on 3/28/24 listed the following blood sugars recorded on 3/19/24: a. 8:07 AM - 364 b. 11:17 AM - 334 c. 4:59 PM - 109 In an interview on 3/19/24 at 8:14 AM, Staff D reported she didn't know to prime the insulin pen needles before she administered the insulin. In an interview on 3/20/24 at 10:11 AM, Staff D reported when she gave Resident #25 the insulin on 3/19/24, she found the facility protocol to prime the needle with 2 units. Staff D notified the doctor and family, rechecked Resident #25's blood sugar at 9:51 AM. Her blood sugar measured 526. She called the provider who gave orders to give an extra 2 units of Lispro and 2 units of Glargine. She administered those orders at 10:10 AM. Staff D informed the oncoming nurse, Staff B, Licensed Practical Nurse (LPN), of the order to recheck the blood glucose again at 10:45 AM. Staff D reported this should be charted in the vitals tab in the electronic medical record. Staff D reviewed the Blood Sugar Summary under the vitals tab, then verified Resident #25's record lacked the blood sugar documented for 10:45 AM under the summary or in the Nurse's Progress Notes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/20/24 at 10:34 AM, Staff B, LPN reported after Staff D gave insulin to Resident #25 on 3/19/24, Staff D reported Staff B needed to recheck the blood sugar at 10:45 AM. She did not remember entering the blood sugar in the Blood Sugar Summary and verified there was no blood sugar documented in the Blood Sugar Summary or progress notes for 10:45 AM. Staff B also reported before she would administer insulin with a pen, she would prime the needle with 2 units. In an interview on 3/28/24 at 11:07 AM, Staff M, RN Clinical Quality Specialist, reported the nurse should follow protocol and prime the needle of the insulin pen with 2 units prior to administration. Immediately after an order is received to administer a medication, the order should be entered into the system. When a resident has orders to recheck the blood sugar in 30 minutes, she expects the nurse to document it in the electronic MAR. The Insulin Pen policy revised July 2016, directed staff prior to administration to: a. Dial a dose of 2 units b. Take off and discard the inner needle cap c. Hold pen with needle pointing up and gently tap the insulin reservoir so any air bubbles rise to the needle d. Press injection button all the way in and count slowly to 6 - A stream of insulin should come through the needle - The dose window will return to zero

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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** 25855 Based on clinical record review, staff interviews, family interviews, and policy review the facility failed to complete skin assessments and provide treatments per physician's orders for 2 of 4 residents reviewed (Residents #14 and #89) with pressure ulcers. Both residents admitted to the facility with skin concerns and the facility failed to document the skin issues until days after their admission. Due to the lack of assessment and intervention the residents' skin injuries went from mild to serious impairment with exposed fat tissue and/or bone. This resulted in an immediate jeopardy situation. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 3/21/24 at 4:44 PM. The IJ began on 1/25/24. Facility staff removed the Immediate Jeopardy on 3/22/24 at 11:03 AM by completing the following: 3/22/24 a. NP (Nurse Practitioner) reviewed all current areas and treatments for appropriateness of current interventions b. Residents with existing areas present a new assessment with measurements was completed 3/21/24 a. All residents were provided head to toe assessments and documented results via progress note. b. Braden Assessments were completed on all current residents c. Re education was completed to all nurses on the skin protocol policy and use of the standing orders, include notification of any new areas, immediate initiation of skin protocol orders, and risk management. d. All residents care plans were audited an updated for skin integrity areas e. Audited pressure reduction devices in place and /or indicated. The scope lowered from J to D at the time of the survey. Findings include: 1. Resident #14's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #14 required substantial/maximal assistance with positioning. In addition, she required total assistance from staff for transferring from bed to chair to toilet, with receiving showers, and when walking. The MDS included diagnoses of a fracture to the right arm, atrial fibrillation (an abnormal heart rhythm) and diabetes mellitus. The MDS indicated Resident #14 had one Stage 2 pressure ulcer present upon admission. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Clinical Admission Form dated 1/25/24 lacked documentation of Resident #14 having a pressure ulcer. The section regarding the skin assessment remained incomplete. The Baseline Care Plan dated 1/25/24 at 7:03 PM failed to identify Resident #14 had a pressure ulcer or any skin conditions. The Physician Assistant's note dated 1/25/24 at 6:49 PM identified Resident #14 had bruising to the left cheek and hand. The note didn't include any assessment of the coccyx area. The Facility Wound and Skin Evaluation forms listed the following information: a. 1/26/24: Coccyx wound measured 13.5 cm (centimeters) long, 0.9 cm wide and no depth b. 1/28/24: Stage 2 pressure ulcer identified to coccyx with an onset date of 1/28/24. The wound measured 5. 7 cm long, 0.8 cm wide and no depth of an intact blister with blanching and erythema, no drainage. The Nutrition/Dietary Note dated 1/30/24 at 1:27 PM the Dietitian documented Resident #14 had a stage 2 pressure ulcer with partial thickness skin loss 5.7 cm long and 0.8 cm wide. The Dietitian would contact the physician for a supplement order, as she needed increased protein for healing related to wound as evidenced by stage 2 partial thickness pressure ulcer. The Note lacked documentation of measurements of the pressure ulcer. The Nurses Note dated 2/2/24 at 7:18 PM the on duty Registered Nurse (RN) called another RN to look at Resident #14's coccyx wound. They assessed the area and took pictures of the wound pictures, then cleansed the area. After cleaning, they applied calcium alginate (a form of a wound treatment) and covered it with an Optifoam dressing. Per Resident #14's request, the nurse contacted Resident #14's daughter to update her on the wound status. The note lacked measurements and the appearance of the wound. The Care Plan Focus initiated on 2/2/24 and revised 2/8/24 indicated Resident #14 had a pressure ulcer on her sacrum. In addition, she had a potential for pressure ulcer development related to immobility, incontinence and diabetes mellitus type 2. The Interventions directed the following: a. Administer treatments as ordered and monitor for effectiveness. b. Assess/record/monitor wound healing weekly and PRN (as needed). Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician. c. Encourage resident to eat and drink all that is offered. d. The resident will have a pressure relief device on the bed and in the chair. On 2/6/24, the Care Plan added the following intervention: Consult with Wound Practitioner as warranted. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/8/24, the Care Plan added the following interventions: a. Assess/record/monitor wound healing weekly and PRN(as needed) Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician. b. Consult with dietician as warrants. c. Obtain ordered labs and report findings to physician d. Resident has low loss air mattress on bed The Nursing Facility Care, Subsequent, Per Day Encounter Note dated 2/6/24 listed the chief complaint as surgical wound to her front chest following the removal of basal cell cancer and an unstageable pressure ulcer to her coccyx/buttocks. Resident #14 had diabetes and lymphedema (swelling caused by a build-up of lymph fluid under the skin). The unstageable pressure ulcer on Resident #14's coccyx measured 5.0 cm by 6. 9 cm with a depth of 0.1-1.1 cm. The wound bed appeared pink, with a large amount of drainage with a mild/moderate odor. The wound contained 90% necrotic slough tissue. The provider recommended a second opinion/possible surgical intervention related to the severity of the wound. The provider couldn't debride (remove dead tissue) the wound due its complexity at the bedside. The provider discussed with Resident #14 and her daughter the severity of her wound with the possible outcomes including wound infection, osteomyelitis (bone infection), sepsis (blood infection), and possible death. The provider gave orders for the following: a. Clean with saline, apply moistened Dakin's 0.125% 4x4 gauze to the wound bed and cover with a sacral foam every shift and as needed (PRN). b. Air mattress/chair cushion for pressure relieving support and protein supplement of 30 milliliters (ml) three times a day for nutritional support (house choice/sugar free). The Skin & Wound Evaluation V7.0 dated 2/9/24 at 10:39 PM indicated Resident #14 had an unstageable pressure ulcer due to slough and/or eschar (dead tissue) on her middle sacrum. The form listed the area as new and in-house acquired. The wound measured 7.6 cm area squared, 2.6 cm length, and 3.7 cm wide. The form reflected depth, undermining, and tunneling as not applicable. The assessment reflected the progress of the wound as stable. The remaining documentation of the assessment remained incomplete regarding appearance, exudate, wound bed, surrounding tissue, and the type of treatment. The Encounter Note dated 2/9/24 reflected Resident #14 saw the provider regarding sores on her lower extremities. Resident #14 and her daughter had concerns regarding the wounds on her lower legs. Her daughter thought the staff had Resident #14's compression dressings too tight. In addition, she had a pressure ulcer on her buttocks, she is scheduled to see the wound center on 2/14/24 regarding the ulcer. Resident #14 reported she had blisters on her legs. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Wound Center Progress Notes dated 2/14/24 identified Resident #14 had wounds on her coccyx, left medial foot at base of big toe-bunion area, left medial calf, right posterior thigh, left anterior upper arm. She had sharp and throbbing constant pain that she rated 8 out of 10, indicating moderate to severe pain. When she lies on her back, the pain increases. She described her pain as increased pain to coccyx, but denied pain to her left foot, left calf, right thigh, and left upper arm. The wounds on the left foot, left calf, right posterior thigh and right upper arm started on 2/8/24 and the coccyx wound started on 1/26/24.The wounds on the left foot and left calf started from the lymphedema wraps. The coccyx, left foot, and right posterior thigh are pressure ulcers, while the left upper arm is a skin tear. Resident #14's daughter came with her, she reported the coccyx wound started on 1/26/24 while in the hospital after falling at home, the left foot and calf wounds started on 2/8/24. After her hospitalization , the daughter reported she went to the nursing home, where she wore lymphedema compression. Once the nurses at the nursing home removed the wraps, they discovered a pressure ulcer on the left calf and foot. The facility staff cleaned the wound with Dakin's, packed the wound, and placed an Allevyn dressing over the wound. The left foot and left thigh wounds had Xeroform and Optifoam Gentle Border dressings. The wound assessments revealed the following: a. Wound #1 Coccyx is a Stage 4 pressure injury remained unhealed. The wound measured 3.5 cm x 2.8 cm x 4 cm (length, width, depth) with an area of 9.8 square (sq) cm and a volume of 39.2 cubic cm. Tendon and adipose tissue were exposed, but no eschar, tunneling, or sinus tracts observed. Undermining was noted at 12:00, extending up to 2.5 cm. The wound exhibited moderate tan drainage with mild odor. Resident #14 reported pain of 8/10. The wound margin was rolled, and the attached wound bed showed bright red, spongy granulation covering 1-25%, slough covering 51-75%, and epithelialization covering 1-25%. The periwound (skin around the wound) skin displayed maceration (skin breakdown caused by moisture), ecchymosis (dark purple spot on the skin similar to a bruise), and erythema (abnormal redness of the skin), with normal local pulse, and no signs of infection. The provider debrided the area of 4.9 sq cm. Following the debridement, the wound measured 3.5 cm length x 2.8 cm width x 4 cm depth, with an area of 9.8 sq cm and a volume of 39.2 cubic cm. b. Wound #2 Left, Proximal, Medial Calf is an acute Stage 3 pressure injury remains unhealed. Initial measurements indicate a wound size of 1 cm x 1.5 cm x 0.1 cm (length, width, depth) with an area of 1.5 sq cm and a volume of 0.15 cubic cm. Adipose tissue is exposed. No tunneling, sinus tracts, or undermining are observed. A scant amount of sero-sanguineous drainage is present, with no odor. Resident #14 reported no wound pain. The wound margin is flat and intact. The wound bed shows pink, firm granulation covering 1-25%, slough covering 51-75%, eschar covering 1-25%, and epithelialization covering 1-25%. The wound is deteriorating. Periwound skin exhibits edema and excoriation, appearing dry and scaly. The temperature of the periwound skin is warm, and there are no signs of infection. Local pulse is absent. c. Wound #3 Left, Medial Foot is a chronic Stage 3 pressure ulcer that measured 1.7 cm x 2.3 cm x 0.1 cm (length, width, depth) with an area of 3.91 sq cm and a volume of 0.391 cubic cm. Adipose tissue is exposed. No tunneling, sinus tracts, or undermining are observed. A scant amount of sero-sanguineous drainage is present, with no odor. The wound margin is flat and intact. The wound bed shows bright red, pink, firm granulation covering 1-25%, slough covering 51-75%, and epithelialization covering 1-25%. No eschar is present. The wound is deteriorating. Periwound skin exhibits edema and excoriation, appearing dry and scaly. The temperature of the periwound skin is warm, and there are no signs of infection. Local pulse is absent. The provider debrided 0.782 sq cm of the wound. Following the debridement, the wound measured 1. 7 cm length x 2.3 width x 0.1 cm depth, with an area of 3.91 sq cm and a volume of 0.391 cubic cm. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Wound #4 Right Thigh is a Stage 3 Pressure Injury that measured 2.2 cm x 2.3 cm x 0.7 cm (length, width, depth) with an area of 5.06 sq cm and a volume of 3.542 cubic cm. Adipose tissue was exposed. No tunneling, sinus tracts, or undermining were observed. A small amount of sero-sanguineous drainage was present, with no odor. The wound margin was flat and intact. The wound bed showed bright red, pink, firm granulation covering 1-25%, slough covering 51-75%, and epithelialization covering 1-25%. No eschar was present. Periwound skin exhibited edema and excoriation, appearing dry and scaly. The temperature of the periwound skin was warm, and there were no signs of infection. Local pulse was normal. The Wound Clinic Progress Notes included the following orders: a. Wound #1 Coccyx: Clean the wound and surrounding area gently using a non-harmful solution. Primary dressing: Until a specialized wound vacuum (wound vac) is available, place a soft material called alginate lightly into the wound. Secondary dressing: Cover the wound with a dressing like Mepilex or a similar one until the wound vac is ready. Change dressings three times a week or as needed. If there are issues with the wound vac, turn it off, remove the sponge from the wound, and use a wet-to-dry dressing temporarily. The wound vac provides continuous suction at a specific pressure level. Black foam is placed in the wound bed and positioned where pressure is low. Make sure the tape secures the foam properly on healthy skin. b. Wound #2 Left, Proximal, Medial Calf: Wound Cleansing: Gently clean the wound and the area around it (peri-wound) using a non-cytotoxic agent. Dressings: Primary Dressing (Xeroform): Apply a layer of Xeroform directly over the wound. Xeroform is a type of dressing that helps protect the wound and keep it moist. Secondary Dressing (Mepilex or similar): Place on top of the Xeroform. Changing Dressings: Change the dressings three times per week or as needed. c. Wound #3 Left, Medial Foot: Gently clean the wound and the peri-wound using a non-cytotoxic agent. Dressings: Primary Dressing (Xeroform): Apply a layer of Xeroform directly over the wound. Xeroform is a type of dressing that helps protect the wound and keep it moist. Secondary Dressing (Mepilex or similar): Place on top of the Xeroform. Changing Dressings: Change the dressings three times per week or as needed. d. Wound #4 Right Thigh Gently clean the wound and the area around it (peri-wound) using a non-cytotoxic agent. Dressings: Primary Dressing (Xeroform): Apply a layer of Xeroform directly over the wound. Secondary Dressing (Mepilex or similar): Place on top of the Xeroform. Changing Dressings: Change the dressings three times per week or as needed. The Order Summary Report reviewed on 3/21/24 included an order dated 2/15/24 regarding the coccyx wound. The order instructed, if the facility couldn't get a wound vac reapplied, they needed to gently cleanse wound with a non-cytotoxic agent, lightly tuck alginate into wound, and cover with mepilex dressing or any comparable dressing. The order directed to change the alginate dressing 3 times per week, every 24 hours as needed. If problems occur with wound vac: turn vac off, remove all sponge from wound, and place wet to dry dressing until problem can be addressed. The February 2024 Treatment Administration Record (TAR) lacked the scheduled order for the coccyx wound ordered at the Wound Clinic. The TAR listed the following orders: a. 2/15/24: As needed order with a start date of 2/15/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Summit of Bettendorf		STREET ADDRESS, CITY, STATE, ZIP CODE 4699 53rd Avenue Bettendorf, IA 52722	

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The only documentation listed on the TAR indicated Resident #14's dressing to her coccyx got changed on 2/16/24. b. 2/15/24: Site: Coccyx Negative wound vac therapy 125mmHg continuous suction. Black foam tucked lightly into wound bed and tracked to area of low pressure. Ensure tape is under all black foam on good skin. Change two times weekly, Monday, Thursday, and as needed (PRN). Check every shift for placement and adherence. - Wound documented as completed on 2/15/24, 2/17/24, and 2/18/24 on the night shift. The Skin/Wound Note dated 2/16/24 at 12:37 PM reflected the facility didn't receive all of the wound vac supplies and they didn't have matching in house products. The nurse contacted the wound vac vendor and they said they would look into the concerns. The nurse notified Resident #14, family and the wound care center. Resident #14 had an order for alternative treatment until the wound vac arrived. The Progress Notes lacked documentation that someone completed the alternative treatment to Resident #14's coccyx wound. The Nurses Note dated 2/19/24 at 10:00 AM indicated the facility spoke with the wound vac vendor. They reported they would send out new supplies (foam dressing kits) of the ones not delivered the week before. The facility did the alternative treatment ordered by the wound clinic. The Nurses Note dated 2/20/24 at 1:34 PM documented the nurse spoke to Resident #14 and her family regarding the wound vac. The nurse told them she could apply the wound vac, but because she has a wound clinic appointment the next day, she recommended not doing the dressing. She explained with the stickiness of the adhesive, if she applied the wound vac, Resident #14 would hurt more tomorrow when they changed it at the wound center. They agreed and the nurse placed the alginate dressing instead. The N Adv Skilled Evaluation dated 2/20/24 at 5:09 PM reflected Resident #14 described her pain to her coccyx as a 10 and sharp, cramping, without radiation. The skin section described Resident #14's coccyx wound as a stage 4 pressure ulcer. The wound bed looked Necrotic (dead tissue), with heavy drainage saturated on the dressing with some wound odor. Resident #14 followed the wound clinic's treatment schedule twice a day. The Skin and Wound Evaluation dated 2/20/24 at 1:44 PM indicated Resident #14 had a new in-house acquired stage 4 pressure ulcer to the middle sacrum. The wound measured 7.0 cm sq area, 3.8 cm long, 2. 5 cm wide. The assessment listed the depth, undermining, and tunneling as not applicable. The assessment did not include documentation of exudate, wound bed, surrounding tissue, or type of treatment. (continued on next page)

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F 0686

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The Wound Clinic Progress Notes dated 2/21/24 described the coccyx wound as an unhealed chronic Stage 4 Pressure Injury Pressure Ulcer. The wound measured 4.5 cm length x 2.8 cm width x 3.4 cm depth, with an area of 12.6 sq cm and a volume of 42.84 cubic cm. They wound had adipose tissue expose, but didn't have tunneling or sinus tract noted. The assessment determined undermining at 7:00 and ends at 4:00 with a maximum distance of 2.1 cm. The wound had a moderate amount of tan drainage noted with a mild odor. Resident #14 reported a wound pain of level 8/10. The wound margin is rolled and attached. The wound bed contained 1-25%, bright red, spongy, granulation, 26-50% slough, 1-25% eschar, 1-25% epithelialization tissue. The note described the wound as deteriorating. The periwound skin exhibited maceration, ecchymosis and erythema. The temperature of the periwound skin is warm, the periwound didn't exhibit signs or symptoms of infection. Local Pulse is Normal.

The Order Summary Report reviewed on 3/27/24 included an order dated 2/22/24 to assess the wound daily even with the wound vac in place. The assessment included drainage (change/color/consistency), volume, adhesion of dressing, and the sponge appearance. In addition, the once a day progress note must have measurements of visible opening, any troubleshooting provided since the last daily assessment, and the appearance of the periwound skin appearance.

The Skin & Wound Evaluation V7.0 dated 2/25/24 at 2:33 PM documented Resident #14's middle sacrum stage 4 pressure ulcer measured 4.2 cm length, 3.9 cm width, with the depth, tunneling, and undermining as not applicable. The assessment lacked documentation of the wound bed, exudate, peri wound, surrounding tissue, or the type of treatment order.

The Order Summary Report reviewed on 3/27/24 included an order dated 2/28/24 to place alginate to the periwound around the edges to prevent foam from being in contact with intact skin. Negative wound vac therapy 125mmHg continuous suction, with the black foam tucked lightly into the wound bed and tracked to area of low pressure. Ensure tape is under all black foam on good skin. Change two times a week, the wound clinic will change on Wednesday, the facility to send the supplies. On Saturday check every shift for placement and adherence. Check the wound vac for function and adherence every shift.

The February 2024 TAR listed the order as needed and didn't include a scheduled treatment.

The Nurses Note dated 2/28/24 at 5:38 PM reflected Resident #14 returned from the Wound Clinic with the same order for her coccyx treatment and other wound injuries. The nurse replaced the wound vac dressing within 2 hours of her return to the facility. The note indicated the nurse staff must ensure the wound vac supplies get sent to the Wound Clinic appointments.

The N Adv Skilled Evaluation Note dated 2/29/24 at 2:23 PM reflected Resident #14 had a pressure ulcer/injury to her coccyx (back of the body above buttocks). The nurse described the wound bed as necrotic with heavy (greater than 75%) dressing saturation and odor. The note indicated Resident #14 follows with the wound clinic treatment schedule of twice a day (BID). The nurse staged the pressure ulcer as a stage 4, full thickness skin and tissue loss. Resident #14 had constant pain from the pressure ulcer.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The N Adv Skilled Evaluation Note dated 3/1/24 at 11:15 AM indicated the pressure ulcer to Resident #14's coccyx had no change. The wound continued necrotic with heavy dressing saturation and odor. The note indicated Resident #14 follows with the wound clinic treatment schedule of twice a day (BID). The nurse staged the pressure ulcer as a stage 4, full thickness skin and tissue loss. Resident #14 had constant pain from the pressure ulcer. The N Adv Skilled Evaluation Note dated 3/2/24 at 1:47 AM indicated the pressure ulcer to Resident #14's coccyx had no change. The wound continued necrotic with heavy dressing saturation and odor. The note indicated Resident #14 follows with the wound clinic treatment schedule of twice a day (BID). The nurse staged the pressure ulcer as a stage 4, full thickness skin and tissue loss. Resident #14 had constant pain from the pressure ulcer. The Skin & Wound Evaluation V7.0 dated 3/2/24 at 2:38 PM reflected a stage 4 pressure to Resident #14's sacrum, middle. The assessment described the wound as new in-house acquired. The wound clinic staged the pressure wound that measured 16.5 cm area square x 4.6 cm length x 4.4 cm width, with depth, tunneling (wound moved under the skin away from the original wound), and undermining (edges of the wound under the skin are slightly larger than the outside of the wound) listed as not applicable. The wound appeared to have 70% of the wound filled with granulation tissue (new tissue, indicating the wound is healing) with 30% of the wound had slough tissue (a form of necrotic tissue that typically appears as soft, yellow, or white tissue). The wound had redness with inflammation indicating evidence of an infection. The wound had moderate serosanguineous drainage (a type of drainage that appears slightly yellow and pink) with a faint amount of odor. The wound had non-attached edges (edges look curled under). The wound appeared red and fragile. Resident #14 rated her pain 5/10 continuous, indicating moderate amount of pain. The wound progress reflected deteriorating. The Skin & Wound Evaluation V7.0 dated 3/10/24 at 5:14 AM identified Resident #14 had an in house acquired stage 4 pressure ulcer to the sacrum middle. The wound measured 18.6 cm area squared x 6.5 cm length x 4.4 cm with depth, undermining, and tunneling listed as inapplicable. Following the measurements, the assessment remained incomplete. On 3/19/24 at 2:00 PM observed Staff E, Licensed Practical Nurse (LPN), enter Resident #14's room. Staff E reported Resident #14 had a wound to her sacrum, to her chest, and to her foot. She had a wound care clinic appointment scheduled for her sacral wound the next day. Staff O, Registered Nurse (RN) and Staff C, Certification Medication Aide (CMA)/ Certified Nurse Aide (CNA), and Staff M, RN/Clinical Quality Specialist entered the room. Resident #14 stated she wanted to urinate. Rather than placing her on a bedpan, the staff waited for her to urinate into her incontinent brief. As Staff O and Staff C turned the resident to her side, the Tegaderm dressing at the bottom of the wound peeled away near the rectal area. An observation revealed an intact Wound Vac that functioned well at 125 mmgHg (millimeters of mercury) suction. Resident #14 had a smear of bowel movement (BM). The wound lacked signs of an infection to surrounding tissue and had no odor noted. The wound contained exposed tendon and bone, Staff C removed her gloves, washed her hands and donned new gloves before she provided proper incontinence care. Staff E used the correct technique to cleanse the wound to the coccyx, however, did not change the wound dressing, the black sponge and Tegaderm to the Wound Vac. After the staff provided incontinence care, they removed their gloves, used alcohol hand sanitizer and donned new gloves before securing a new incontinent brief in place. The air mattress was in place and inflated properly. Staff E and Staff C placed Resident #14's feet in Prevalon boots and turned her to lay on her left side, placed a wedge pillow behind her back, and another pillow between her knees. The side ensured both 1/4 side rails were up with her call light in reach. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Wound Clinic Progress Note dated 3/20/24 indicated on 2/28/24 when Resident #14 went to her appointment, she didn't have her wound supplies as ordered. At this appointment, Resident #14 rated her pain at 9/10, indicating severe pain. The assessment revealed she had a large amount of leakage around the wound vac. She had all of her dressings in place and brought her wound supplies. She continued to have an unhealed stage 4 pressure injury to her coccyx. The wound measured 7.3 cm long, 5 cm wide and 4.7 cm deep. The area measured 35 sq and had a volume of 171.55 cubic cm. The wound had exposed tendon, muscle, bone and adipose (fatty tissue) with a moderate amount of tan drainage noted with a strong odor. The assessment reflected she had pain of 8/10. The note described the wound as deteriorating. The Wound Clinic debrided the wound and removed 18.25 sq cm of devitalized tissue; biofilm, fibrin, and slough. The final measurement of the wound was 7.3 cm in length, 5 cm width, and 4.7 cm deep. The area measure 36.5 sq cm with a volume of 171.55 cm. The Wound Clinic gave orders of Alginate to the peri wound around the edges to prevent foam from being in contact with intact skin. Change dressing two times per week and PRN (as needed). Negative wound vac therapy per nursing home,125 mmHg continuous suction, please use Versatel or Adaptec placed into wound base to protect bone, black sponge. On 3/20/24 at 1:12 PM, the ADON (Assistant Director of Nursing) reported upon review of the skin and wound evaluation form completed on 3/11/24, she verified the documentation didn't identify the wound. She explained the area identified as a wound was to her right groin. She couldn't explain why Resident #14's record didn't have documentation of Resident #13's coccyx wound. In addition, she couldn't explain how the ulcers developed. The ADON described the area to Resident #14's coccyx as a pressure ulcer and verified the admission assessment dated [DATE] didn't have documentation of the date of onset. Upon review of the admission progress notes, the ADON verified Resident #14's admitted as 1/25/24 and the initial progress note dated 1/25/24 at 6:45 PM lacked documentation of Resident #14's pressure ulcer. She added the nurse should have completed a head to toe skin assessment on both progress notes and the admission assessment. If Resident #14 had pressure ulcers on admission, the nurse should have documented the location, measurements, appearance, any drainage, and odor. She felt the wound could have developed due to lack of positioning. The ADON couldn't explain the lack of documentation. She reported the staff should have reassessed the wound and measure it every 7 days. The ADON reported her Care Plan interventions included a low air loss mattress and supplements. On 3/20/24 at 2:28 PM, Staff G, RN, reported when a resident admitted to the facility for the first time, the nurse should complete a head to toe skin assessment on the admission clinical admit form within 2 hours. She explained she started the form, but didn't get to complete the skin admission assessment and passed it on to the next shift. The nurse should document pressure ulcer assessments on the skin and wound evaluation forms every 6 to 7 days. She added Resident #14 went to the wound clinic once a week. She could not explain how the wound developed or if she had it upon admission, she did acknowledge the current wound as a stage 4. The Care Plan interventions included: pressure relieving mattress, protein supplements, paper chux (thin protective barrier) reposition, check and change every 2 hours. The Skin & Wound Evaluation V7.0 dated 3/22/24 at 4:06 PM identified Resident #14 had an in house acquired stage 4 pressure ulcer to the sacrum middle. The wound measured 6.5 cm long, 4.4 cm wide, with depth, tunneling, and undermining listed as not applicable. The goal of care indicated the wound healed slowly or stalled but stable with little to no deterioration. The notes reflected the wound looked more granulated and healthier. The education indicated the facility would continue to twice weekly wound changes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Incident Report Head to Toe assessment dated [DATE] at 7:02 PM reflected the wound vac dressing didn't include a layer of protection under the black foam bridge to the lower area of pressure causing a suction irritation under the foam. The skin looked bright red. Resident #14 described the area as tender and irritated. The nurse applied the correct dressing. The Safety Measures Implemented section indicated the nurse applied the correct dressing and directed management to provide wound vac dressing change education. On 3/21/24 at 8:15 AM, Staff C, Certified Medication Aide (CMA)/Certified Nurse Aide (CNA) reported Resident #14 admitted to the facility with a pressure ulcer. She couldn't recall the size of the wound. She explained the wound may have opened as she has been incontinent of urine and stool. The staff had to reduce her Colace (a laxative). She had some days the staff found her soaking wet. Staff C thought Resident #14 might benefit from having a catheter. Her she had watery consistency stools and they started a couple of weeks before. The Care Plan interventions included repositioning Resident #14 every 2 hours. Staff C explained Resident #14 repositioned without issue. The staff helped her get in her power chair so there is not so much pressure on her bottom. There is a special mattress that fluctuates the pressure, only use one non fitted sheet and use paper chux. Staff C didn't know how long Resident #14 had the mattress. She had a wound vac that Wound Clinic changed once a week on Wednesdays. On 3/21/24 at 8:22 AM, Staff F, CNA reported Resident #14 had a spot on her bottom when she came in, but it was nowhere as big as it is now. The last time Staff F saw the wound on 3/17/24, she had no redness around the wound, but the tissue looked [NAME] with lots of drainage. She had the wound vac, but couldn't recall the date the wound clinic was placed. Staff F said the wound may have opened due to Resident #14 incontinence of urine and stool. On the first shift, the staff change her every time they reposition her as she would be incontinent of large amounts of urine and stool. Staff F reported she cleaned feces (poop) out of Resident #14's wound. The staff used to put her on the bedpan, but with the wound vac and where the wound is, t