STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	08/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Drumm Retirement Center	5837 Winwood Drive Johnston, IA 50131

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** 46873 Based on clinical record review, resident and staff interviews, and facility policy review, the facility failed to prevent the development of a pressure ulcer for 1 of 3 (Resident #1) residents reviewed. The resident was admitted with one Stage IV pressure ulcer, having comorbidities which made her susceptible to further impaired skin integrity. The facility failed to provide recommended every 2 hour repositioning, and failed to do all ordered skin treatments. This failure resulted in Immediate Jeopardy to the health and safety of the resident when she developed a second stage IV pressure ulcer, which required multiple antibiotics and medical intervention during a hospital. The facility reported a census of 119 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 8/17/24 at 4:05 pm. The IJ began on June 9, 2024. Facility staff removed the Immediate Jeopardy on 8/18/24 through the following actions: -Skin assessments conducted on all residents with active wounds, and reviewed and revised treatments orders as necessary -Braden scale assessments (an assessment to predict pressure ulcer risk) conducted on all residents -Policies regarding Pressure Injury Prevention and Turn/Repositioning reviewed and updated as needed -Education provided to all nursing staff of policies and procedures related to skin/wound care, turning and repositioning -Audits put in place to be completed 5 days a week to ensure accurate and complete documentation of skin related treatments -Audits put in place to be completed on 3 residents per week for observation of treatments, preventative skin care and weekly skin assessments -A QAPI (Quality Assurance Performance Improvement) action plan was initiated (continued on next page)

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	The scope lowered from J to D at the time of the survey after ensuring the facility implemented the education, audits and their policy and procedures. Findings include: Determining the Stage of Pressure Injury: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. 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. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. The Minimum Data Set (MDS) dated [DATE] of Resident #1 identified a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS revealed the resident to be dependent on rolling side to side and chair/bed-to-chair transfers. The MDS coded the presence of an indwelling catheter. The MDS reflected the resident always incontinent of bowel. The MDS documented diagnoses that included: Diabetes Mellitus, paraplegia and spinal stenosis. The MDS revealed the resident had one Stage IV pressure ulcer, which had been present upon admission to the facility. The MDS additionally revealed the resident to have Moisture Associated Skin Damage. The MDS documented that resident admitted to the facility as 9/15/2023. The Comprehensive Care Plan of Resident #1, initiated 9/20/23, identified a Focus Area of Skin Breakdown, dated 9/26/23. The Care Plan directed staff to encourage the resident to turn side to side when in bed to decrease pressure, dated 9/26/23. The Care Plan failed to direct staff of a turning/repositioning schedule. The Care Plan failed to document that the Skin Breakdown Focus Area had been updated since 2023. The Focus Area ADL (Activities of Daily Living) self-care performance deficit, dated 9/26/23 directed the resident required 2 staff members to reposition and turn in bed, dated 9/26/23. The Care Plan failed to document the resident to be non-compliant with repositioning. The Nurse's Note dated 6/9/24 at 12:15 p.m. revealed multiple abrasions were noted on the resident's tailbone with small amounts of bleeding. An order was received for topical wound care. The Encounter note dated 6/10/24 at midnight by the house Nurse Practitioner documented the resident to have a wound on her buttocks and stated the resident was seen by and cared for by a wound care provider once a week. She documented the resident does not turn in bed without staff assistance. The resident complained of increased pain from a wound on her buttocks. The Nurse's Note dated 6/10/24 at 2:58 p.m. documented ensure (a protein drink) ordered with meals for wound healing due to the resident refusing liquacel (a high protein supplement). A Skin/Wound Note dated 6/11/24 at 6:13 p.m. documented an open area to the sacrum with a small amount of serosanguinous (a mixture of blood and serum [the liquid part of blood]) drainage noted. It stated the surrounding skin to have blanchable erythema. The Wound Evaluation and Management Summary dated 6/11/24 documented the initial evaluation of a non-pressure wound to the sacrum. The Wound Advanced Registered Nurse Practitioner (ARNP) ordered alginate calcium with a gauze bordered dressing for 30 days. (Alginate is used for wounds with exudate). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Treatment Administration Record (TAR) for June of 2024 revealed the above order was implemented as ordered, documented as being done June 12th through June 16th, 2024. It was discontinued on June 17th, 2024. The Order Audit Report documented the order was discontinued on 6/17/24 by Staff A, Registered Nurse (RN) at 3:47 am. The reason was documented as New Order Received. The Progress Notes failed to document any new orders received on 6/16/24 or 6/17/24. The TAR failed to document any treatment being completed on the sacrum between June 16th and June 21st when a new order was received. The TAR for June of 2024 showed the calcium alginate order with gauze was re-started on 6/21/24 and documented as completed through 6/25/24. On 6/25/24 a new order was given to apply alginate calcium and Santyl (an ointment used to remove damaged tissue from chronic pressure ulcers or burns) and to continue the use of the bordered dressing. There were no wound treatments for the sacral wound documented as being completed 6/17/24 - 6/20/24 or on 6/26/24. The Skin & Wound Evaluation dated 6/18/24 documented the resident to have a new unstageable pressure ulcer, 1 week old, house acquired, which was described as 100% of the wound being filled with eschar (dead tissue which forms over wounds). Per the definition of pressure injuries, eschar is not present until the injury reaches at least a Stage 3 Pressure Injury. The Wound Evaluation and Management Summary dated 6/18/24 documented the sacrum wound to be 4 x 3 x 0.1 cm, listed as moisture associated skin damage and repeated the orders from the prior week of alginate calcium and a gauze island bordered dressing daily. The Wound Evaluation and Management Summary dated 6/25/24 documented the sacrum wound to be 7 x 3 x 0.1 cm. The wound progress was documented as exacerbated due to the patient not offloading as she should and not telling the aides when she is wet. An order was placed to continue the same treatment, but to add Santyl as part of the treatment. (Santyl is an ointment used to remove damaged tissue from chronic skin ulcers, or debriding of a wound). The Wound ARNP did not see the resident again after 6/25/24 until 7/16/24. The Skin and Wound Evaluation dated 7/2/24 documented the sacral wound as being Moisture Associated Skin Damage, house acquired, with measurements documented 9 x 7 x 0.2 cm. The Evaluation documented the wound was 10% filled with granulation and 90% filled with eschar. Additional documentation included a moderate amount of serous exudate, and attached wound edges. The Evaluation documented Provider recommended off-loading the wound and letting staff know when soiled, nursing staff educated on making sure resident's briefs are changed frequently throughout the day. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/15/24 at 3:32 pm, the Wound ARNP stated when she saw the wound on 6/25/24 the wound was not a pressure injury. She stated it may have worsened after she saw it prior to admitting to the hospital. She stated the resident can assist in repositioning but is unable to turn herself in bed without staff assistance. The Point of Care charting portion of the resident's record, where the Certified Nurse Aides (CNA) document cares, revealed the section of Rolling left and Right was to be documented 3 times a day (once a shift), every day, for the month of June. The documentation was left blank 17 times during the month of June. The Point of Care charting revealed the section of Skin: Turn and Reposition at least every 2 hours was also left blank 17 times during the month of June. On 8/15/24 at 4:12 pm, the Director of Nursing (DON) stated the CNAs only chart in Point of Care. She stated there is nowhere else the turning is documented to show it is being done. She also stated the resident does not comply with repositioning all of the time. On 8/15/24 at 4:30 pm, Staff B, Registered Nurse (RN), acting in house wound nurse, stated he was not familiar with the wound prior to the resident's hospitalization . He stated he only saw it after she returned from the hospital. He stated based on the description in the Skin and Wound assessment, the wound did not sound like it was Moisture Associated Skin Damage. He stated at times MASD can break down further and lead to pressure ulcers. The Encounter Note dated 7/5/24 by the facility ARNP documented an acute visit was made due to labs showing an elevated white blood cell count (an indication of infection) and a urinalysis which indicated a need for a culture to be done. The WBC count was 20.9 (normal range 4.5 - 11). The resident's blood pressure was slightly low and heart rate was 99. The note documented a concern of sepsis (a serious condition in which the body responds improperly to an infection). The ARNP recommended the resident be sent to the Emergency Department for further evaluation. The records from the acute care hospital documented upon arrival to the Emergency Department, the resident had a WBC count of 23.4 and a C-reactive protein of 27.2 (an indication of inflammation in the body). The Patient Active Problem list identified: - Pressure ulcer of the left ischium, Stage 4 - Pressure injury of sacral region, Stage 4 - Incomplete paraplegia - Diabetes Mellitus, type 2 - Degenerative arthritis of the spine - Lumbosacral spondylosis without myelopathy - Acquired kyphosis (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Status post cervical spinal fusion - Lumbar radiculopathy- Lumbar spinal stenosis (all comorbidities which could put the resident at a higher risk of impaired skin integrity). The Computed Tomography (CT) scan dated 7/5/24 documented the pressure ulcers and chronic osteomyelitis of the coccyx (a long-term bone infection which can develop, be treated and return). The CT also showed subcutaneous emphysema (development of air under the skin which may indicate deeper pathological issues). The History and Physical documented a prior history of multiple decubitus ulcers, with admission diagnoses of sepsis secondary to cellulitis and chronic osteomyelitis associated with a large decubitus ulcer. The resident was referred to plastic surgery for wound debridement and was treated with multiple antibiotics. The note stated the resident also had rhinovirus (the common cold) and a UTI which was noted to be another possible source of infection. The resident was discharged from the hospital on 7/15/24, listed in stable condition with wound care orders in place for ischium and sacrum pressure ulcers to be done twice daily. The Wound ARNP visited the resident on 7/16/24 and wrote orders to initiate a wound vac for the pressure ulcers (a vacuum-assisted device used for closure of a wound). On 7/22/24 the Director of Nursing (DON) documented a Nurse's Note that stated the orders that were received on 7/16/24 were being initiated on this date (7/22/24). The note documented the wound practitioner and the spouse of the resident were informed of the late initiation of orders. On 8/17/24 at 10:09 am, Staff C, Licensed Practical Nurse (LPN) stated she had worked with Resident #1 often since beginning employment greater than 6 months ago. She stated the sacral wound was open and she would have considered it a pressure injury, not Moisture Associated Skin Damage. On 8/17/24 at 10:55 am, the Wound ARNP verified wound #1 in her weekly wound charting is referring to the resident's initial pressure ulcer that was present on admission. This pressure ulcer is on her left ischium (the curved bone forming the base of each half of the pelvis). Her notes document this wound as being on her coccyx (tail bone). She stated she considers the buttocks, the coccyx and the ischium to all be basically the same spot. The resident's skin was observed on 8/17/24 at 11:40 am. The wound vac was in place and running as ordered, with the sponges covering two wounds on the left ischium and on the sacral area. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/17/24 at 1:22 pm, the DON stated the Wound ARNP comes every Tuesday. She stated the in house wound nurse had been working overnight shifts covering the floor, so Staff B, RN had been acting as the in house wound nurse to assist. She stated each week when the Wound ARNP comes she (the DON) prefers to discuss all of the wounds with the in house wound nurse. She stated it had been very busy and there had not been a discussion of the wound orders from 7/16/22. She said on 7/22/24, she asked to have a conversation with Staff B about the wounds and at that time he informed her he had not implemented any of the orders received that on 7/16/24. He stated he had been busy all week and had not had a chance to place the order in the Electronic Health Records of the residents. She stated there were orders for 4 residents. She stated she immediately contacted the wound vac supplier and it was delivered the following day. On 8/18/24 at 8:25 am, Resident #1 stated she is supposed to be supported by a pillow on one side of her body, and then the pillow is supposed to be switched to the other side of her body every couple of hours. She stated that sometimes it happens on time and sometimes it takes a long time to get somebody. She stated she thinks part of the reason it takes a long time is the staff thinks it takes two people to reposition her but she feels if the staff know how to do it, it can be done with one person. She stated at that moment, she was lying on her back with no pillows under her. She stated she was not sure how long it had been since anyone had been in to reposition her. She said occasionally she has a staff member who will stick to the schedule and let her know exactly when they will be back to reposition again, but she considers it rare when staff follow through. On 8/18/24 at 8:37 am, Staff C, LPN stated Resident #1 prefers to be on her back during meals. But with encouragement she will reposition. She stated she has never had the resident refuse to reposition during times she has cared for her. On 8/18/24 at 8:41 am, Staff D, CNA stated the resident occasionally says no when she is asked about repositioning. On 8/18/24 at 8:46 am, Staff E, CNA stated at times when she offers to reposition Resident #1, the resident will tell her she is ok for now. She stated she can ring her call light when she wants repositioned. She stated if the resident refuses repositioning, it should be charted in Point of Care as refused. On 8/18/24 at 9:05 am, Staff F, Certified Medication Aide (CMA) stated Resident #1 is to be turned side to side only. He stated Resident #1 has never refused repositioning when he has worked with her. On 8/18/24 at 9:09 am, Staff G, RN, stated she works all over the building but is familiar with Resident #1. She stated to turn the resident and prop a pillow, it can be done with one staff member but she generally also needs to be boosted up in bed which requires 2 staff members. She stated the resident is fully alert and oriented and she has never refused cares for her. She stated the resident will ring her call light and also request to be turned at times. The undated facility policy Turning and Repositioning documented It is our policy to implement turning and repositioning as part of our systematic approach to pressure injury prevention and management. This policy establishes responsibilities and protocols for turning and repositioning. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Policy Explanation and Compliance Guidelines documented: Repositioning will be documented in the resident's plan of care, and will be determined by the resident assessment which may include Braden Scale for predicting Pressure Sore Risk and/or like assessment as determined by the facility. The facility policy Pressure Injury Prevention and Management, review date 10/22/22 documented This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Point 2: The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Point 4d. -Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. -i. Pressure injuries will be differentiated from non-pressure injuries, such as arterial, venous diabetic, moisture or incontinence related skin damage. -ii. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge and surrounding tissue characteristics.