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	165530	A. BUILDING _____ B. WING _____	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 9/22/17 for F252, 10/6/17 for all other F tags. The following deficiencies relate to the facility's health survey and investigation of complaints #70267-C and #70874-C. Complaint #70267-C was substantiated. Complaint #70874-C was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 252		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/29/2017

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.

POC accepted 10/12/17 KS

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F 252	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the staff failed to provide a safe, sanitizable environment. The facility reported a census of 63 residents. Findings include: During environmental tour on 9/13/17 at 10:00 a.m. revealed the following concerns: *room 105 door to be marred *room 115 had a black kick plate with areas of peeling *the left door (facing the dining room) on the double doors leading into the 1st floor dining room a quarter sized chunk of wood protruding from the door *room 202 door had a black kick plate with multiple areas peeling *room 212 and 225 doors had a black kick plate with pieces missing and marred areas throughout the door *room 221 and 227 door to be marred *room 230 bathroom door has a hole towards the bottom of the door with splintered wood noted. Frame to the right of the door has chunks of paint missing. Three holes on the back of the bathroom door noted. The room door is marred *room 231, 232, 234 and 2nd floor whirlpool room door had black kick plate multiple areas peeling During a staff interview on 9/13/17 10:00 a.m. the Maintenance Supervisor stated he is currently working on replacing the kick plates on the doors throughout the facility.	F 252		

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F 252	Continued From page 2 On 9/13/17 at 12:00 p.m. observed the Maintenance Supervisor making repairs on some of the doors of concern.	F 252		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, facility staff failed to follow physician orders for 1 of 13 current residents reviewed (Resident #2) and failed to administer insulin appropriately for 1 of 1 resident reviewed (Resident #3). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/24/17 documented Resident #2 with severely impaired cognitive skills for daily decision making. The MDS recorded Resident #2 required the assistance of two with bed mobility, transfers and s/he did not walk. Resident #2 had diagnoses that included Non-Alzheimer's Dementia (a progressive deteriorating condition), peripheral vascular disease (PVD, a lack of blood supply to extremities), dysphagia (easily chokes) and anxiety disorder.	F 281		

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F 281	Continued From page 3 Review of the Physician Orders dated 8/1/17 revealed an order to keep the resident's head of bed (HOB) elevated 30 degrees due to high risk aspiration. The resident's 9/17 Treatment Administration Record also recorded the order and staff signed off on it on 9/12/17 from 7 a.m. to 11:59 p.m. Observation on 9/12/17 at 7:37 a.m. revealed Resident #2 lay in bed with the bed in the flat position. Staff had not elevated the resident's HOB. An interview with the Director of Nursing (DON) on 9/14/17 at 7:50 a.m. revealed physician orders should be followed by staff. 2. According to the MDS assessment dated 8/14/17, Resident #3 had diagnoses that included diabetes mellitus and chronic kidney disease. The MDS documented Resident #3 received daily insulin injection(s). Resident #3's TAR for 9/17 instructed staff to administer Humalog (insulin) 13 units (U) subcutaneously twice a day before the noon meal and supper. Observation on 9/11/17 at 11:51 a.m. revealed Staff A Registered Nurse (RN) had administered Resident #3's insulin via a Humalog insulin pen. Staff A cleansed the injection site, administered the insulin and left the room. Staff A failed to hold the insulin pen in place for 10 seconds during administration. The facility's Insulin Pen Administration policy dated 10/15/15 instructed staff to administer insulin by inserting the needle and pressing and	F 281		

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F 281	Continued From page 4 holding the dose button. After the dose counter reaches 0, slowly count to 10 and then release the dose button. Releasing the button prior to the 10 count may result in incorrect dosing. During interview on 9/13/17 at 1:45 p.m. the DON stated staff should have held the insulin pen in place for 10 seconds before removing it from the resident.	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to follow the care plan interventions for 1 of 13 current residents reviewed (Resident #2). The facility reported a census of 63 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 7/24/17, documented Resident #2 with severely impaired cognitive skills for daily decision making. The MDS recorded Resident #2 required the assistance of 2 with bed mobility, transfers, dressing and toilet use. Resident #2 had diagnoses that included non-Alzheimer's Dementia (a progressive deteriorating condition),	F 282		

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F 282	Continued From page 5 peripheral vascular disease (PVD, a lack of blood supply to extremities), dysphagia (easily chokes) and anxiety disorder. Review of the care plan with a start date of 11/19/15 revealed a problem for ADL (activities of daily living) functional/rehabilitation potential and an intervention to have foam boots (pressure relieving boots) on at all times. The care plan with a start date of 5/10/16 revealed a problem with falls and an intervention dated 6/2/17 to keep foot of bed slightly elevated to support the resident's legs being pulled up in fetal position. An observation on 9/12/17 at 7:37 a.m. revealed Resident #2 in bed with the lights off. The bed sat in a flat position with no elevation of the head or feet. The foam boots were not on the resident's feet, but on the chair at the foot of resident's bed. An observation on 9/12/17 at 9:48 a.m. revealed Staff F, Certified Nurses Aide (CNA) and Staff I, CNA assisted the Resident #2 into bed. Staff did not elevate the foot of the resident's bed and it remained in the flat position. An observation on 9/13/17 at 3:27 p.m. revealed Resident #2 in bed without foam boots on their feet or the foot of bed elevated. An interview with the Director of Nursing on 9/14/17 at 7:50 a.m. revealed her expectation would be for staff to follow the care plan as it is written.	F 282		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents.	F 323		

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F 323	Continued From page 6 The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility record review and staff interview, the facility failed to provide adequate supervision to prevent accidents for 1 of 10 residents reviewed (Resident 15). Record review revealed Resident #15 required staff assistance for transfers and toilet use. The facility call light log and staff's statements, revealed Resident #15 waited approximately 39 minutes on the toilet until staff responded to his/her call light and found the resident on the floor face down. Resident #15 sustained injuries including a cervical spine fracture. Staff E reported she knew Resident #15	F 323		

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F 323	Continued From page 7 had been on the toilet but went to assist another resident. Staff H reported nurses receive alerts on a pager if a call light had been on for over 10 minutes however, that day he could not find a pager. The facility reported a census of 63 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 5/15/17 indicated Resident #15 had a Brief Interview of Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS listed the following diagnoses for Resident #15: anxiety, chronic kidney disease, chronic obstructive pulmonary disease, and stress incontinence. The MDS indicated Resident #15 required extensive assistance of 1 staff for bed mobility, transfers and extensive assistance of 2 staff for toilet use. Review of Resident #15's care plan with a revision date of 5/22/17 revealed staff are to assist (1 staff) with activities of daily living and assist of 2 with sit to stand or use of walker, gait belt and assistance of 2 for transfers (per resident's preference). Staff is to check and change resident frequently as s/he is incontinent of urine. Record review of Resident #15's event report dated 8/03/17 at 11:18 a.m. identified on 8/3/17 at 8:00 a.m., Resident #15 fell in the bathroom. Staff documented Resident #15 had been alone/unattended at the time of the fall. Staff found Resident #15 on the floor with injuries to his/her head (laceration to forehead), extremities, trunk and left hand, however the resident denied neck pain. The resident rated his/her pain at 4 out	F 323		

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F 323	Continued From page 8 of 10 (moderate pain distressing, miserable-verbalized by moaning). Resident #15's range of motion was limited/painful in upper extremity-could not lift arm for transfer, and staff observed no rotation/deformity/shortening noted. Resident #15 had no falls/fracture in the past and had been wearing gripper socks at the time of the incident. The report documented factor/s related to the fall, such as lost of strength /appeared to get weak and the resident had been sitting on the toilet prior to the fall. Review of contributing factors listed toileting status. The even report indicated following the fall, staff will supervise the resident in bathroom. Review of Resident #15's progress note in an event report documented : stat call to resident's room at approximately 8:14 a.m. by Certified Nursing Assistant. The writer was downstairs at the time and ran upstairs to respond to call. Another nurse was already present in room applying pressure to head wound. There was moderate amount of blood on floor under the resident's head (no other areas of blood noted). Resident was lying under the sink with head towards wall on top of walker, arms folded underneath and feet pointed towards the toilet. The walker was underneath resident and appeared right below his/her chest level. Resident #15 answered simple questions slowly (which is normal) and was alert. The report documented 911 called at approximately 8:18 a.m and arrived at 8:25 a.m. Resident repositioned in bathroom with use of blankets. Resident #15's walker removed from underneath and blanket used to remove resident from bathroom by sliding on floor. Resident transferred to backboard and c-collar applied by emergency medical team. Resident #15 was transferred to emergency	F 323		

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F 323	Continued From page 9 room. Review of Resident #15's chart revealed a neurosurgeon consult with a date and time of 8/3/17 at 6:37 p.m. revealed a CT scan was reviewed and demonstrated a type II odontoid fracture (peg or dens fracture) without displacement. CT of the head was negative. Review of Resident #15's hospital history and physical with a date and time of 8/3/17 at 5:16 p.m. revealed the resident fell in the bathroom at the nursing home and struck his/her head on the sink during an unwitnessed fall. When the resident was brought to the emergency room upon arrival he/she was confused and unable to answer questions. The resident had a forehead laceration which was sutured. A computerized axial tomography (CAT) scan revealed a C2 fracture (cervical spine) through the base of the odontoid process. [A peg of bone called the odontoid process (sometimes called the dens). The odontoid process sticks up from the front of C2 and fits into a groove in C1.] The resident received Diluadid and morphine to address his/her pain. The resident remained lethargic and was admitted to the hospital. According to the Certificate of Death, on 8/13/17 at 3:30 a.m., Resident #15 died at the hospital. Resident #15's manner of death was classified as an accident from a ground level fall. The immediate cause of death listed odontoid fracture with the date of injury on 8/3/17. According to the call light log, given by Administrator revealed the bathroom call light for Resident #15 was cleared on 8/3/17 at 8:20:34 a.m. with a reset time of 39 minutes and 1	F 323		

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F 323	Continued From page 10 second. On 9/13/17 at 12:40 a.m. the Administration stated the time on the log, with the date, is when the call light was cleared. A written statement by Staff E documented on 8/3/17 around 7:30 to 7:40 a.m., she put Resident #15 on the toilet and the resident stated he/she wanted to sit on the toilet for a little bit so Staff E went to assist another resident. Staff E documented when she was done, she went back to Resident #15's room to shut off his/her call light and found him/her head first under the sink with blood all over the floor. During a staff interview on 9/12/17 at 6:04 p.m. Staff E stated she worked on 8/3/17, she split the hall with Staff F. Staff E stated she had gotten Resident #15 up to the toilet at about 7:45 a.m. and asked if Resident #15 wanted to sit and the resident said yes. So Staff E gave Resident #15 the call light then went to room 214 to assist the residents in there. After Staff E assisted those residents, she went in to Resident #15 room, room 213 and found the resident on the floor at about 8:05 a.m. but wasn't certain on the time. Staff E stated Resident #15 used a walker, gait belt, and 1 staff for transfers and never got up by themselves, would use the call light. Staff E stated residents can be left alone in the bathroom unless the care plan says not to. Staff E stated Resident #15's care plan never said someone had to be in the bathroom with him/her. When asked how she knew a call light was going off Staff E stated it pops up on a reader screen by the elevator and it shows up on the pagers. Staff E stated the pagers go off for bathroom and bedroom lights. Staff E stated only CNAs had pagers not the nurses that day. Staff E stated	F 323		

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F 323	Continued From page 11 since the incident now everyone has a pager. If the call light is on, after 10 minutes the management/department heads will get a page. Staff E stated the staff will then ask nursing staff to shut off the call light. Staff E stated the Director of Nursing (DON) pulled up the video from the hall and said she saw her partner (Staff F) had walked by the room and never assisted Resident #15 and walked next door. Staff E stated the DON said Staff F should have turned the light off. During a staff interview on 9/21/17 at 2:15 p.m. Staff F CNA stated she was working the morning of Resident #15's fall on 8/3/17. Staff F stated she and Staff E CNA split the hall that day; Staff F had North Hall and Staff E had South Hall. Staff F stated Resident #15 would call if assistance was needed. Staff F stated Resident #15 used to use an EZ-stand mechanical lift but worked with physical and occupational therapy and was using a walker, gait belt and staff assistance for transfers. Staff F stated Resident #15 had a riser on their toilet seat, but the resident's feet never touched the floor. When asked what happened on 8/3/17, Staff F stated Staff E had assisted Resident #15 on the toilet before breakfast (before 8:00 a.m.) and Staff G CNA was assisting Staff F with other getting other residents up. Staff F walked down the hall and saw Staff E walk out of Resident #15's room and said call "nurse stat" Resident #15 is on the floor. Staff F said this was roughly about 8:10 a.m. as Resident #15 was the only one left in their room. Staff F said she saw Resident #15 lying face down on the floor on top of their walker. When Staff F was asked if she was in Resident	F 323		

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F 323	Continued From page 12	F 323		

#15's adjoining room she indicated she was in there around 8:00 a.m. and saw Resident #15 on the toilet. Staff F stated she saw Resident #15's call light on a few times that morning. When Staff F was asked about when the pagers go off she stated they go off whenever a call light is turned on, even for the bathroom light. The pagers will go off until the light is shut off but if it's on passed 10 minutes the nurse's pagers will go off. Staff F stated residents can be left alone in their bathroom unless their care plan says otherwise. When asked if Staff E seemed distracted that day, she stated that Staff E talks too much about her personal life and her mind always seems elsewhere.

Review of the facility's investigation for the incident on 8/3/17 revealed Staff F's statement as follows: Staff F was taking care of a resident with another CNA then came out and Staff D had her check on a resident in 211 bed. At 7:50 a.m. Staff F got a washcloth and noticed Resident #15 on the toilet and was fine. Staff F then left and checked on another resident, came out to the hall and Staff E said to call nurse stat that Resident #15 was on the floor.

During a follow up staff interview on 9/14/17 at 1:50 p.m., Staff F was asked what she meant in her facility statement when she stated she noticed Resident #15 seated on the toilet and fine. Staff F stated when she saw Resident #15 s/he was fine, sitting on the toilet.

During a staff interview on 9/13/17 at 12:00 p.m. Staff G CNA stated she worked on 8/3/17 but on a new hall. Staff G stated once her tasks were completed she went to the North/South to assist with other residents. Staff G stated she first

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 helped Staff F and that's when Staff E ran out of room 211 and said to page for nurse stat. Staff G stated Staff F went in to the bathroom of room 211 to see what happened. Staff G stated after the incident more of the management team has pagers that go off if a call light is on passed 10 minutes. Staff G also stated that nurses are supposed to have the 10 minute pagers too. When asked if Staff E seemed distracted that day, Staff E stated you have to tell her what to do, like if a light was going off, you'd have to tell her to get it. During an interview on 9/13/17 at 1:00 p.m. the DON stated they could not save the video footage for the incident that took place on 8/3/17. During a staff interview on 9/13/17 at 1:27 p.m. Staff D Licensed Practical Nurse (LPN) stated she did work on 8/3/17. Staff D stated she had gone in Resident #15's bathroom before 8:00 a.m., between 7:30 a.m. and 7:40 a.m. to administer medications and resident had just transferred to the toilet. Staff E was still in the room and the call light was not on at that time. Staff D stated she gave Resident #15 their meds and left the room, but Staff E was still there. Staff D stated she heard the nurse stat call about 8:15 a.m. from downstairs then ran upstairs to assist. Staff D stated Staff H LPN was already in the bathroom applying pressure to the resident's head. Staff D stated she called 911. She was unsure if the call light was on. When asked who has the pagers, Staff D stated at the time of the incident she could not find a working pager, so she did not have one. She stated that if a call light is on for more than 10 minutes the nurses get paged and after the incident all department heads have pagers.	F 323		

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F 323	Continued From page 14 During a staff interview on 9/13/17 at 2:15 p.m. Staff H stated he worked on 8/3/17 and was working on new Hall when he heard the nurse stat call around 8:00 a.m. Staff H stated when he arrived he found Resident #15 face down on top of the walker with a laceration to his/her head. Staff H stated all nurses and CNAs have pagers, but that day he could not find one. Staff H stated nurses receive pages if a call light has been on over 10 minutes. Since the fall he believes the facility has obtained more pagers. Review of the facility's investigation for the incident on 8/3/17 revealed Staff H's statement as follows: Approximately 8:12 a.m. responded to a nurse stat to room 211-213 bathroom. Resident #15 was witnessed to be face down on top of walker. Blood was coming from head, immediately applied pressure to wound. Told Staff D to call 911. Kept pressure on wound. Resident was conscious. Asked if she was hurting anywhere, stated his/her left hand hurt. Resident #15 became restless. Calmed him/her down and told him/her we can't move until the ambulance had arrived. During a staff interview on 9/14/17 at 12:15 p.m. the Administrator stated Resident #15 didn't try to get up on his/her own and was not an impulsive person. At the time of the incident it is the busiest time of day. The Administrator stated she watched the video and it showed Resident #16 turned on their call light right as staff walked out of the room. She's not sure what they could have done differently as she believes the resident passed out then fell on the floor.	F 323		
F 353	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING	F 353		

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F 353 SS=E	Continued From page 15 STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed	F 353		

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F 353	Continued From page 16 nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility record review and group and individual resident interviews, the facility failed to answer call lights in a time frame that met resident needs for 2 of 13 current residents reviewed (Residents #1 and #4) and for 2 of 5 residents during the group interview. The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/28/17 documented Resident #1 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated no memory or cognitive impairment. The MDS documented s/he required the assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene activities. During interview on 9/11/17 at 8:04 a.m. Resident #1 stated the night before, his/her call light wasn't answered for 20 minutes. During further interview on 9/12/17 at 1:38 p.m. Resident #1 stated a call light response takes 20 - 25 minutes for staff to answer. Resident #1 also stated staff said s/he would have to wait as they	F 353		

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F 353	Continued From page 17 were with other residents. Review of the Device Activity Report dated 9/13/17 revealed the call light on in resident's rooms for over 15 minutes 27 times from 9/10 to 9/12/17. The report also recorded Resident #1 call light on for 38 minutes and 19 seconds on 9/12/17 at 9:24 a.m. and over 45 minutes on 9/10/17 at 9:37 p.m. 2. The MDS assessment dated 6/30/17 documented Resident #4 had a BIMS score of 15, which indicated no memory or cognitive impairment. The assessment documented the resident required the assistance of two staff with bed mobility, transfers, dressing and toilet use and the assistance of one with locomotion on and off the unit and with personal hygiene. An interview with Resident #4 on 9/12/17 at 1:45 p.m. revealed concern with staff taking 30 minutes to 2 hours to answer their activated call light. Resident #4 pointed to the wall clock when asked how s/he timed the response. 3. During a Group resident interview on 9/11/17 at 2:26 p.m. when asked if anyone had issues with call lights being answered, 2 of 5 residents present stated that staff shut off the call light and say they will come back, but it's about 30 minutes later before they return to assist the residents.	F 353		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 441		

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F 441	Continued From page 18 a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	Continued From page 19 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and facility policies the facility failed to utilize infection control techniques during medication pass, incontinent cares and a dressing change for 4 of 13 current residents reviewed (Residents #1, #3, #7 and #9). The facility reported a census of 63 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 8/14/17, Resident #3 had diagnoses that included diabetes mellitus and chronic kidney disease. The MDS documented Resident #3 received daily insulin injection(s). Observation on 9/11/17 at 11:51 a.m. revealed	F 441		

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F 441	Continued From page 20 Staff A Registered Nurse (RN) had obtained Resident #3's blood sugar. Staff A washed her hands, donned gloves, obtained Resident #3's blood sugar, the went back to the medication cart in the hallway, disposed of the used supplies and removed her gloves. Staff A placed the glucometer (machine used to test blood sugar) on top of the medication cart. Staff A then obtained the insulin pen and placed the disposable needle on the pen and entered Resident #3's room. Staff A donned gloves and administered 13 units of Humalog in Resident #3's abdomen. Staff A gathered supplied used and disposed of them, putting the glucometer in the medication cart and started charting on the lab top attached to the medication cart. Staff A failed to perform hand hygiene after obtaining Resident #3's blood sugar and administrating insulin and she failed to sanitze the glucometer after use. During interview on 9/13/17 at 1:30 p.m., the Director of Nursing (DON) stated staff should perform hand hygiene after the blood sugar was obtained and after administering the insulin. Staff should also use a sanitizer wipe to cleanse the glucometer after use. 2. According to the MDS assessment dated 9/4/17, Resident #7 had diagnoses that included bladder cancer, gastroesophageal reflux disease, paraplegia and chronic lung disease. The MDS indicated Resident #7 had two Stage 3 pressure ulcers present on admission, one Stage 4 pressure ulcer present on admission and one unstageable pressure ulcer present on admission. The assessment also recorded the facility applied dressings and medications as part of the resident's skin and ulcer treatments.	F 441		

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F 441	Continued From page 21 Observation on 9/13/17 at 2:25 p.m. revealed Staff H, Licensed Practical Nurse (LPN) had completed Resident #7's dressing changes. Staff H had supplies on a rolling table; he went to move the rolling table with the supplies on it and the wound cleanser spray bottle fell on the floor. Staff H picked up the bottle from the floor and placed it on the rolling table. Staff H used the cleanser one time after it fell on the ground, but did not sanitze the bottle after picking it up from the floor. On 9/14/17 at 12:10 p.m. the DON stated she would have expected staff to get a new wound cleanse bottle before finishing the wound cares. 3. According to the MDS assessment dated 7/7/17, Resident #9 had diagnoses that included diabetes mellitus, depression and hypertension. The MDS indicated Resident #9 required the assistance of one staff with toilet use and personal hygiene activities and s/he experienced frequent urinary incontinence. Observation on 9/12/17 at 9:25 a.m. revealed Staff B Certified Nursing Assistant (CNA) and Staff C CNA had performed peri-cares. Staff B obtained a trash bag, touched Resident #9's heel protectors then obtained multiple adult wipes using her bare hands. Staff B then sanitized her hands, donned gloves and assisted Resident #9 to position in bed using a Chux (a bed liner) Staff B then unfastened Resident #9's adult brief and touched clean adult wipes and peri-care wash with the same gloved hands, without performing hand hygiene. Staff B put the adult wipes and peri-care wash down and asked for Staff C to assist. Staff C washed her hands, donned gloves and assisted Staff B with incontinent cares. Staff B failed to perform hand hygiene and don gloves	F 441		

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F 441	Continued From page 22 before handling the clean adult wipes and peri-care wash. On 9/13/17 at 1:45 p.m. the DON stated staff should have removed gloves and sanitized their hands before putting on new gloves and performing peri-cares tasks. The DON stated she would not expect staff to handle clean items once gloved hands became dirty. The facility's handwashing/hand hygiene policy, revised 5/10/16, instructed that in most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use of alcohol-based hand rub containing 61 - 95% ethanol or isopropanol for all of the following situations: before and after direct contact with residents, after contact with resident's skin, after contact with objects in the immediate vicinity of the resident and after removing gloves. 4. The MDS assessment dated 8/28/17 documented Resident #1 had diagnoses that included osteoarthritis (joint deterioration), chronic kidney disease and type 2 diabetes mellitus. The assessment documented s/he required the assistance of one with toilet use and personal hygiene, supervision during walking and use of a walker as a mobility device. An observation on 9/12/17 at 8:45 a.m. revealed the Assistant Director of Nursing (ADON) assisted Resident #1 with perineal cares due to bowel incontinence. The ADON performed all the perineal cares and then, while wearing the same gloves and without any hand hygiene, touched the resident's walker to move it.	F 441		

The following constitutes Glen Haven Home's response to the regulatory deficiencies noted from the inspection completed 9/14/17. The facility does not admit to truth or accuracy of the statements or allegations contained in the statement of deficiencies; however the facility remains committed to the delivery of high quality health care and services and will continue to make whatever changes and improvements that may be necessary to satisfy those objectives.

Please consider this response our credible allegation of compliance, effective October 6th, 2017

F252 Safe/Clean/Comfortable/Homelike Environment

Marred areas were repaired on doors to rooms 105, 212, 225, 221,227 and 230 by sanding, restaining and using polyurethane. Kickplates were repaired on rooms 115, 202, 212, 225, 231, 232, 234 and 2nd floor whirlpool room. The left door (facing the dining room) on the double doors leading into the 1st floor dining and the room 230 room and bathroom doors were repaired using Wood Bondo wood putty. Door frame in room 230 was repainted. All repairs were completed by Friday 9-15-17.

All staff were re-educated on 10-3-17 on providing a safe, sanitizable environment and the process for submitting work orders to the Maintenance department. The Maintenance staff also completed an inspection of all other doors, door frames and kickplates in the facility. Repairs were completed on 10-6-17.

Monthly facility walkthroughs will be conducted by Maintenance Director or designee to look for uncleanable surfaces. Findings will be reported each month to the QAPI committee for review and comment.

F281 Services Provided Meet Professional Standards

The care plan and pocket care plan for Resident #2 was updated during survey to include physician order for head of bed to be elevated and was added to pocket care plans. Nurse responsible for insulin given was re-educated at time of survey following error a competency was completed 9/20/17. This nurse demonstrated competency at that time.

Verbiage "per MD" will be added to care plans for any new physician orders and during quarterly care plan meetings beginning 10-6-17 in order to differentiate between facility interventions and physician ordered interventions in order to ensure discharge orders

Julie Mawatt
Administrator

will be obtained prior to removal of any physician ordered interventions from the care plans. Insulin administration competencies were completed on all nurses.

Eight random resident care plan audits will be completed monthly by the DON or designee per month for the next three months then 4 per month for the next three months. Nurse competency on insulin administration will be completed quarterly for all nurses. Results will be reported to the QAPI committee.

F282 Services By Qualified Persons/Per Care Plan

For Resident #2 random daily checks done 5 x per week by DON or designee until compliance is reached for correct position and equipment in place.

To ensure pocket care plans are being followed for all residents, 4 random pocket care plan audits each for 10 residents will be completed throughout the building each week by DON or designee for 2 months. If compliance is reached then they will be reduced to 2 per week for an additional 2 months. Results will be reported monthly to the QAPI committee.

F323 Free of Accident Hazards/Supervision/Devices

Facility unable to correct for resident 15 as she did not return to the facility.

The facility identified the call light issue following the incident on 8-3-17. On that date 10 minute call light pagers were handed out to department heads, activity staff and medical records to be monitored at all times when on duty and hold nursing staff accountable for answering per facility policy. Those staff are required to assess the situation and provide assistance when a call light reaches 10 minutes. On 9-18-17 Nurse pagers were adjusted to 8 minutes to ensure a more timely intervention when CNAs are unavailable.

Pager Call Light System Policy was reviewed and updated. Facility staff on were educated beginning on 9-18-17 individually on the policy including expectations related to call lights and ensuring all nursing staff, department heads, activity staff have functioning communication devices available to include a walkie, and pager.

Glen Haven Home's Safety and Supervision of Residents Policy states "The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment." The nursing team was educated on

8-8-17 during a nursing team meeting on the importance of following Pocket Care Plans/ Care Plans to ensure resident specific needs are met. Pocket Care plans for all residents were reviewed by 9-22-17 to ensure establish a baseline for accuracy of information by the Nursing Leadership Team.

Call Light reports will be reviewed by Administrator/ DON or designee each business day to monitor progress related to reduction of the average call light time and analysis of trends. Average call light times and action items related to trends identified during weekly monitoring will be reported monthly to QAPI by the DON or designee and by the Administrator/designee to the monthly Resident Council to ensure resident satisfaction with the facility efforts.

To ensure pocket care plans are being followed for all residents, 4 random pocket care plan audits each for 10 residents will be completed throughout the building each week by DON or designee for 2 months. If compliance is reached then they will be reduced to 2 per week for an additional 2 months. Results will be reported monthly to the QAPI committee.

F353 Sufficient 24-Hr Nursing

The facility identified the call light issue following the incident on 8-3-17. On that date 10 minute call light pagers were handed out to department heads, activity staff and medical records to be monitored at all times when on duty. Those staff are required to assess the situation and provide assistance when a call light hits 10 minutes. Call light trends are discussed daily as needed at the stand-up committee.

Pager Call Light System Policy was reviewed and updated. Facility staff were educated beginning on 9-18-17 individually and as a group on 10-3-17 on the policy including expectations related to call lights and ensuring all nursing staff, department heads, activity staff have functioning communication devices available to include a walkie, and pager.

Call Light reports will be reviewed by Administrator/ DON or designee each business day to monitor progress related to reduction of the average call light time and analysis of trends. Average call light times and action items related to trends identified during weekly monitoring will be reported monthly to QAPI by the DON or designee and by the

F441 Infection Control, Prevent Spread, Linens

Staff A RN was re-educated at time of survey following error and glucometer and hand hygiene competencies were completed 9/20/17. Staff H LPN was re-educated following error and a hand hygiene competency was completed on 10-6-17. Staff B and C CNAs were educated following their errors and hand hygiene competencies were completed on 10-6-17. ADON was reeducated following error. A hand hygiene competency was completed on 10-5-17.

All facility staff were educated on infection control principles and best practices 10-3-17 during an all team meeting. Those not present will be educated during next worked shift. Glucometer competencies were completed for all LPNs/RNs on shift on 10-6-17. Others will be completed prior to next administration. Hand hygiene competencies have been completed for all nursing staff on shift as of 10-6-17 others will be completed during next worked shift.

Competency testing will be completed on all nursing staff for hand hygiene during routine cares quarterly. Nurse competencies on glucometers will be completed quarterly for all nurses. Additionally, 3 random hand hygiene audits will be performed per week during various routine cares for the first month and then 4 audits monthly once compliant for 3 months then quarterly. All results will be reported to the QAPI committee monthly.

Compliance Date 10-6-17

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 140	50.7(1)a(3) Additional Notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(1) Of any accident causing major injury. a. "Major injury" shall be defined as any injury which: (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report to Department of Inspections and Appeals (DIA) a fall experienced by Resident #9 which resulted in a fracture and hospitalization for one of ten residents reviewed. The facility identified a census of 63 current residents. Findings include: The Minimum Data Set (MDS) assessment tool dated 3/13/17 indicated Resident #9 had a Brief Mental Status Interview score of 13 indicating no cognitive impairment. The MDS listed the following diagnoses for Resident #9: hypertension, depression, abnormal gait and mobility. The MDS indicated Resident #9 required	C 140	POC 9/15/17	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0521	A. BUILDING: _____ B. WING _____	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 140	Continued From page 1 extensive assistance of one staff for bed mobility, and transfers and total dependence of 1 staff for locomotion on and off the unit. The MDS indicated Resident #9 utilized a walker and wheelchair. Review of Resident #9's care plan with a revision date of 3/24/17 revealed staff to assist with activities of daily living with assist of 1. Staff is to remind Resident #9 to use the call light and ask for assist. Resident #9 may use a wheelchair as needed. Review of Resident #9's event report dated 3/28/17 at 8:38 a.m. identified the resident fell on 3/28/17 at 7:30 a.m., in their room. Staff documented the unwitnessed fall most likely happened when Resident #9 attempted to self-transfer without staff assistance and lost their balance. Staff found Resident #9 on floor, unable to move leg, unable to complete range of motion, and in intense pain (rated pain at 10 out of 10). Resident #9 had been in bed prior to the fall and wearing shoes. Resident #9 can be left alone and unattended in his/her room. Resident #9 had fallen within the past 6 months. Review of Resident #9's progress note noted on 3/28/17 8:54 a.m. at 7:00 a.m. nurse was called to the resident's room by staff, Certified Nursing Assistant (CNA) had walked by room and saw that resident was lying on floor. Resident could be heard yelling help me. Nurse observed that resident was lying on right side on floor in middle of room and was crying. Resident was stated he/she broke his/her leg. Resident stated he/she was getting up out of bed and fell. Staff obtained vitals while nurse made call to 911. Squad arrived at 7:40 a.m. and exited building with resident around 8:10 a.m. to transfer to emergency room.	C 140		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 140	Continued From page 2 Review of Resident #9's chart revealed an emergency room discharge summary with a signed date and time of 3/28/17 at 10:08 a.m. revealed a left hip and pelvis X-ray was obtained and showed a left intertrochanteric hip fracture. Review of Resident #9's care plan with a revision date of 4/1/17 revealed Resident #9 returned from the hospital on 4/1/17 under Medicare Part A to receive physical therapy and occupational therapy after the left hip fracture. During interview on 9/13/17 at 11:00 a.m. the Administrator state this was missed and should have been reported to the Department of Inspections and Appeals.	C 140		

The following constitutes Glen Haven Home's response to the regulatory deficiencies noted from the inspection completed 9/14/17. The facility does not admit to truth or accuracy of the statements or allegations contained in the statement of deficiencies; however the facility remains committed to the delivery of high quality health care and services and will continue to make whatever changes and improvements that may be necessary to satisfy those objectives.

Please consider this response our credible allegation of compliance, effective 9-15-17

C140 Additional Notification

Following the incident on 3-28-17, the charge nurse notified the DON and Administrator per facility policy, however the DON and Administrator failed to report the injury to DIA. All Department Heads and the Nursing Leadership Team were re-educated on definition of major injury and requirements and timelines to report falls with major injury within 24 hours of notification of major injury to DIA on 9-15-17.

The daily standup meeting's daily agenda includes a resident to resident agenda item that is discussed each business day. The agenda was modified on 9-15-17 to include falls with injury to verify all necessary reports have been made as required.

All reportable events will be reported per guidelines to DIA and will be reported at monthly QAPI meetings for review and recommendation of needed system or policy updates.

Compliance Date 9-15-17

Julie Maurath
Administrator