STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165530	A. BUILDING _____ B. WING _____	09/13/2018

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 10-4-18 The following deficiencies relate to the facility's health survey and investigation of a self-report incident #78144-I. Incident #78144-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		10-4-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julian Urquiart	Administrator	09/27/2018

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 10/15/18 vk

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F 622	Continued From page 1 resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or	F 622		

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F 622	Continued From page 2 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to provide discharge and medical information to the receiving health care institution at the time of discharge for three of three residents reviewed who transferred to the hospital (Resident #2, #34, and #50). The facility reported a census of 57 residents. Findings include: 1. Record review of the most recent MDS (minimum data set) assessment dated 8/27/18 revealed Resident #2 last re-entered the facility from the hospital on 5/16/18. Review of the facility's electronic medical record	F 622		

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F 622	Continued From page 3 documentation system revealed the resident discharged from the facility on 5/1/18, 5/9/18 and 5/15/18. The facility initiated re-entry MDS assessments on 5/3/18, 5/10/18, and 5/16/18. The after visit summary revealed the resident had a hospitalization 5/1-5/3/18 and 5/9-5/10/18 for a diagnoses of kidney stones. The transition orders and continuation of patient care information revealed the resident hospitalized 5/9 - 5/10/18 due to a diagnoses of nephrolithiasis (kidney stones). A SBAR (a communication tool, or situation, background, assessment, request/recommendation) sent to the physician dated 5/15/18 revealed the resident transferred to the hospital due to fever and possible ileus (an obstruction in the bowel). The clinical record lacked documentation of information sent with resident when the resident transferred to the hospital on 5/1/18, 5/9/18 and 5/15/18. In an interview 9/11/18 at 4:54 PM, the Director of Nursing (DON) acknowledged they didn't have a list of medical record documentation or items they sent when a resident transferred to the hospital. The DON reported she expected staff send a copy of the resident's code status and the doctor's order. The DON reported the nurse on duty had the option to fill out a referral form and include the nursing notes. The DON reported they had no capability to retain a copy of what documentation had been sent with the resident to the hospital or the online documentation sent, and typically had not made a copy of the	F 622		

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F 622	Continued From page 4 documentation. In an interview 9/12/18 at 4:36 PM, Staff O, Licensed Practical Nurse reported a copy of the face sheet, advanced directive/code status, the reason a resident transferred, insurance information, and bed hold information sent when a resident had transferred to the hospital. Staff O stated they had not made copies of forms sent to the hospital. 2. Review of the MDS assessment dated 7/19/18 revealed Resident #34 had re-entered the facility from the hospital on 7/13/18. The MDS indicated the resident had chronic obstructive pulmonary disease (COPD). Review of the facility's electronic record documentation system revealed the resident had discharged on 7/10/18 with an anticipated return, and the facility initiated an Entry MDS on 7/13/18. A SBAR communication tool to the physician dated 7/10/18 revealed Resident #34 had difficulty breathing and transferred to the Emergency Room (ER). The discharge document from the hospital revealed Resident #34 admitted 7/10/18 for a diagnoses of pneumonia, and discharged from the hospital on 7/13/18. The progress notes dated 7/1- 7/18/18 revealed the following: 7/10/18 - resident admitted to the ER for pneumonia 7/13/18 - resident re-admitted to the facility The clinical record lacked documentation of	F 622		

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F 622	Continued From page 5 information sent with resident when the resident transferred to the hospital on 7/10/18. 3. Review of the MDS assessment dated 8/16/18 revealed Resident #50 re-entered the facility from the hospital on 8/11/18. The MDS indicated the resident had diagnoses of urinary tract infection (UTI), diabetes, and multiple sclerosis. Review of the on-line computer software program used by the facility for electronic medical records documentation revealed the following: a. Resident #50 discharged on 8/3/18 and the facility initiated an Entry MDS on 8/6/18 b. Resident #50 discharged on 8/8/18 and the facility initiated an Entry MDS on 8/11/18. The transition orders and information for continuation of care document from the hospital recorded Resident #50 admitted 8/3/18, and discharged from the hospital on 8/6/18. A SBAR communication tool to the physician dated 8/8/18, revealed Resident #50 became lethargic and unresponsive and transferred to the Emergency Room (ER). The progress notes dated 8/1- 8/11/18 revealed the following: 8/3/18 - resident sent to the ER 8/6/18 - resident arrived to the facility (after hospitalized) for diagnoses of sinus infection and generalized weakness 8/8/18 - resident became unresponsive in bathtub, and call placed to 911; resident admitted to the hospital for diagnoses of a UTI. 8/11/18 - resident arrived to the facility following a hospital stay	F 622		

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F 622	Continued From page 6 The clinical record lacked documentation of information sent with resident when the resident transferred to the hospital on 8/3/18 and 8/8/18.	F 622		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		9-12-18

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F 623	Continued From page 7 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and	F 623		

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F 623	Continued From page 8 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify the state Ombudsman of the hospitalization of 2 out of 15 residents reviewed (#34 and #42). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/1/18 for Resident #42 identified diagnoses of atrial fibrillation (irregular heartbeat), anxiety and recent urinary tract infection. The MDS documented the resident required the assistance of one with transfers, ambulation in the room and extensive assistance of one for toileting and personal hygiene.	F 623		

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F 623	Continued From page 9 Review of the Nurse's Progress Note dated 7/23/18 documented Resident #42 left the facility with a staff member for a doctor's appointment. The Progress Note documented at 3:04 P.M. the resident admitted to the hospital from the clinic. A Nurse's Progress Note dated 7/26/18 indicated the resident returned to the facility at 5:44 P.M. that date. Documentation of notification of the Ombudsmen is absent from the resident's health record. During an interview with the Social Services Director at 1:15 P.M. on 9/12/18, she stated she thought she sent the July 2018 transfers and discharges to the state Ombudsman on 8/2/18 but realized today that she had only sent the resident's names that were discharged with no anticipated return and expired residents when she attempted to open the list, She faxed the resident's names that were transferred to the hospital in July 2018 at 1:33 P.M. on this date (9/12/18). 2. Review of the clinical record for Resident #34 revealed the resident discharged from the facility on 7/10/18 and hospitalized. The clinical record lacked documentation of notification to the LTC Ombudsman that Resident #34 discharged to the hospital as required by federal regulation. Review of the MDS assessment tool dated 7/19/18 revealed the resident had most recently admitted on 7/13/18 after being hospitalized. Review of the on-line computer software program used by the facility for electronic medical records documentation revealed the resident had discharged on 7/10/18 with a return anticipated, and the facility initiated an Entry MDS on 7/13/18.	F 623		

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F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to notify the resident or resident's representative of a bedhold as required for three of three residents reviewed who were discharged/transferred from the facility (Residents #2, #34, and #50). The facility reported a census of 57 residents.	F 625		10-4-18

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F 625	Continued From page 11 Findings include: 1. The Minimum Data Assessment (MDS) tool dated 8/27/18, documented Resident #2 last reentered the facility from the hospital on 5/16/18. Review of the facility's electronic medical record documentation system revealed the resident had discharged from the facility on 5/1/18, 5/9/18, and 5/15/18. The facility initiated a re-entry MDS on 5/3/18, 5/10/18, and 5/16/18. Review of Resident 2's medical record revealed no documentation of notification to the resident or resident's representative regarding the bed-hold policy when the resident transferred to the hospital on 5/1-5/3/18, 5/9 - 5/10/18, and 5/15-5/16/18. In an interview 9/11/18 at 4:25 PM, the Social Services Director reported the nursing staff had responsibility for notification to the resident or resident's representative about the bed hold policy when a resident transferred from the facility In an interview 9/12/18 at 4:36 PM, Staff O reported a copy of the bed hold information is sent when a resident transferred to the hospital. Staff O stated they had not made copies of forms when a resident sent to the hospital or had resident or family sign anything pertaining to the bed hold. Staff O stated she would document in the progress note anything that pertained to bed hold notification. 2. The MDS assessment dated 7/19/18, documented Resident #34 last reentered from the hospital on 7/13/18.	F 625		

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F 625	Continued From page 12 Review of Resident #34's medical record revealed no documentation of notification to the resident or resident's representative regarding the bed-hold policy when the resident transferred to the hospital on 7/10/18. Review of the facility's electronic medical record documentation system revealed the resident had discharged on 7/10/18 with a return anticipated, and an Entry MDS initiated on 7/13/18. The progress notes dated 7/1 - 7/18/18, revealed the resident admitted to the hospital for pneumonia on 7/10/18, and readmitted to the facility on 7/13/18. 3. Record review of the most recent MDS assessment dated 8/16/18 revealed Resident #50 had re-entered the facility from the hospital on 8/11/18. Review of Resident 50#'s medical record revealed no documentation of notification to the resident or resident's representative regarding the bed-hold policy when the resident transferred to the hospital on 8/3/18 and 8/8/18. Review of the facility's electronic medical record documentation system revealed the resident had discharged on 8/3/18 with a return anticipated, and the facility initiated an Entry MDS on 8/6/18, then discharged on 8/8/18 and the facility initiated an Entry MDS on 8/11/18. The transition orders and information for continuation of care document from the hospital revealed Resident #50 admitted 8/3/18, and discharged from the hospital on 8/6/18.	F 625		

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F 625	Continued From page 13 A SBAR (Situation, Background, Assessment, Request/Recommendation) communication tool to the physician dated 8/8/18, revealed Resident #50 had become lethargic and unresponsive and transferred to the Emergency Room (ER). The progress notes dated 8/1- 8/11/18 revealed the following: 8/3/18 - resident sent to the ER 8/6/18 - resident arrived to the facility (after hospitalized) for diagnoses of sinus infection and generalized weakness 8/8/18 - resident became unresponsive in bathtub, and call placed to 911; resident admitted to the hospital for diagnoses of a UTI. 8/11/18 - resident arrived to the facility following a hospital stay The clinical record lacked documentation of bed hold information provided to the resident or resident's representative when the resident transferred to the hospital on 8/3/18 and 8/8/18.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		10-4-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166530	A. BUILDING _____ B. WING _____	09/13/2018

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F 656	Continued From page 14 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to develop and update a comprehensive care plan to monitor side effects for psychotropic medications for one of three residents reviewed on psychotropic medications (Resident #25). The facility reported a census of 57 residents. Findings include:	F 656		

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F 656	Continued From page 15 1. The Minimum Data Set (MDS) assessment dated 6/29/18 identified Resident # 25 had impaired short and long-term memory, and severely impaired decision making skills. The MDS identified the resident had diagnosis of Non-Alzheimer's dementia without behavioral disturbances. Resident #25 had no behavioral symptoms at the time of the assessment. The MDS recorded the resident took an antianxiety and an antipsychotic medication during the previous 7 day look-back period. The care plan revised on 9/6/18 documented Resident #25 had dementia. The interventions instructed staff to administer medication as ordered, offer reassurance when he became anxious, encourage deep breathing to relax and rest, and offer to walk with the resident when he asked or stated repetitively. The care plan lacked identification of the resident's antianxiety or antipsychotic medications and potential side effects related to the medications. The physician orders dated 8/1/18 instructed staff to administer lorazepam 0.5 mg every 6 hours as needed (PRN). The original order started on 7/4/18. The medication administration record (MAR) dated July, August, and September 2018, revealed lorazepam 0.5 mg PRN administered 7/4, 7/9, 7/12, 7/14, 7/16, 8/12, 8/15, 8/16, 8/22, 8/23, 8/25, 8/26, 9/8 and 9/20/18. During an interview 9/13/18 at 11:17 AM, Staff Q, MDS Coordinator stated the facility developed a care plan within 48 hours of a resident's admission to the facility. Staff Q reported if a	F 656		

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F 656	Continued From page 16 resident had behaviors and received medication, they added the information to the care plan. Staff Q stated some medications entered on the care plan and/or MAR/TAR (treatment administration record).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff	F 657		10-4-18

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F 657	Continued From page 17 Interview, the facility failed to update the comprehensive care plan for two of fifteen residents reviewed (Residents #26 and #46). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/2/18 documented Resident #26 had diagnoses of diabetes, thyroid disorder, and neuromuscular bladder dysfunction. The MDS indicated the resident required the assistance of one staff for toileting and had an indwelling urinary catheter. The care plan dated 9/19/12 revealed the resident had a stroke and a flaccid neuropathic bladder. The care plan indicated the resident had an indwelling catheter but provided no staff directives regarding catheter care or management of the catheter. The pocket care plan (for direct care staff) revealed Resident #26 had a catheter. The pocket care plan had no other information pertaining to the staff directives for the catheter cares. In an interview 9/13/18 at 11:17 AM, Staff Q, MDS Coordinator reported care plans are developed whenever a resident admitted to the facility and whenever they had updated information to add to the care plan. Staff Q explained if the resident had a catheter, they added interventions to the care plan for what the nurse needed to perform and information is added to the pocket care plan as to what interventions needed to be done by the nursing assistants.	F 657		

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F 657	Continued From page 18 2. According to the MDS assessment dated 9/3/18, Resident #46 had a BIMS score of 14 , indicating no cognitive impairment. The MDS did not list any mental diagnoses. The MDS listed the resident received the following medications during the 7 day review period: antipsychotic for 7 days, antianxiety for 2 days and antidepressant for 7 days. Review of Resident #46's care plan, with an edit date of 9/12/18, revealed she will frequently yell out, refuse to eat and cry. The care plan stated Resident #46 is not easily redirected. The care plan lacked approaches for staff to utilize when Resident #46 yelled out or cried. The care plan contained no non-pharmacological interventions for staff to use before they administer an as needed (PRN) medication. Review of the Medication Administration Record (MAR) for the month of August revealed Resident #46 had an order for Ativan (antianxiety) 0.5mg twice a day (BID), PRN. According to the MAR, Resident #46 received this PRN order 17 times during the month of August. Review of the MAR for the month of September revealed Resident #46 had an order for Ativan 0.5mg BID, PRN. According to the MAR, Resident #46 received this PRN order on 9/4/18 and 9/7/18. During a staff interview on 9/13/18 at 8:20 AM, the DON stated the Social Service worker is responsible for putting behavior interventions on the care plan. She stated she would have her update the care plan. Review of Resident #46's updated care plan	F 657		

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F 657	Continued From page 19 provided to the survey team by the DON on 9/13/18 revealed the following approaches for staff to utilize: When she is crying Resident #46 wants staff to talk with her 1 on 1 and let her express her feelings or concerns. Offer her activities, talk about her family or any other subject she may want to talk about. When she is not easily redirected get another staff member that she may have a better relationship with if possible to do 1 on 1 with her. When staff are assisting Resident #46 and she is yelling out, have staff explain to her what they are doing and give her a few seconds to respond and repeat as necessary.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 review of staff training documents, the facility failed to ensure staff provided indwelling catheter care based on professional standards for 2 of 4 residents reviewed (#16 and #57) that had urinary catheters. The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #57 dated 8/29/18, listed diagnoses of unilateral inguinal hernia with obstruction,	F 658		10-4-18

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F 658	Continued From page 20 malignant neoplasm of the bladder and benign prostatic hyperplasia. The MDS documented he had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment for daily decision making. The MDS documented Resident #57 required the assistance of two people for bed mobility, transfers, dressing, and toilet use and the assistance of one person with personal hygiene. The resident had an indwelling urinary catheter upon admission on 8/15/18. During an observation of catheter care on 9/11/18 at 2:45 PM, Staff E and Staff N, both Certified Nurse's Aides (CNA's) washed their hands and donned gloves while Resident #57 lay in his bed. The CNA's pulled down his outer pants and the incontinence product resident wore. Staff E cleansed the head of the resident's penis and catheter tubing at the urethral opening using 3 alcohol prep pads. Staff E then removed her gloves, pulled up the incontinence product and outer pants and both CNA's washed their hands. Review of a document labeled Catheter Care Competency, the document lists under Section C. Equipment and Supplies the following will be necessary: 1. Wipes 2. Personal protective equipment (PPE) During an interview on 9/11/18 at 2:50 PM, Staff E stated she had been in nursing for 16 years and she learned to do catheter care on a male by using an alcohol prep pad (approximate 1 inch by 1 inch square pad containing alcohol and prepackaged) to prevent infection.	F 658		

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F 658	Continued From page 21 During an interview on 9/11/18 at 3:45 PM, the Director of Nursing (DON) stated she expected incontinence wipes would be used for personal care of a resident with a catheter. The DON stated alcohol prep pads are used on the catheter bag ports when the catheter is emptied. The DON stated if there was something stuck on the catheter tubing she could understand the use of an alcohol pad to remove it but otherwise staff would use the incontinence wipes. During interview with the DON on 9/12/18 at 9:00 AM, the DON stated staff are taught to use incontinence wipes for care and she would not have thought they would use alcohol wipes on anything but the catheter bag ports or catheter tubing itself. The DON stated she will make the competency checklist more specific for the kind of wipe to be used for catheter care and had already done education with the staff involved in the catheter care observation on 9/11/18. 2. According to the MDS assessment dated 6/19/18, Resident #16 had a BIMS score of 10, indicating moderate cognitive impairment. The MDS indicated Resident #16 required the assistance of 1 staff for bed mobility and the assistance of 2 for toilet use. The MDS also listed Resident #16 had an indwelling catheter (including a suprapubic catheter) for urination. The MDS listed the following diagnoses for Resident #16: neurogenic bladder, urinary tract infection (UTI), dementia, anxiety, and depression. A review of Resident #54's care plan with a revision date of 9/101/8 revealed she has a suprapubic catheter due to her neuromuscular dysfunction of bladder diagnosis.	F 658		

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F 658	Continued From page 22 Observation on 9/12/18 at 7:05 AM revealed Staff D Certified Nursing Assistant (CNA) and Staff B CNA performed suprapubic catheter stoma site cares for the resident. Staff B used alcohol wipes to clean the suprapubic catheter stoma site. Staff D then used adult wipes to cleanse to the drainage tubing.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of facility orientation guidelines and staffing education, the facility failed to keep 1 of 2 residents (Resident #54) safe after a fall by moving them prior to a nurse completing an assessment. The facility reported a census of 57 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 8/20/18, Resident #54 had a Brief Interview of Mental Status (BIMS) score of 13, indicating no cognitive or memory impairment. The MDS listed Resident #54 required the assistance of one staff for bed mobility, transfers,	F 684		9.14.18

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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 684	Continued From page 23 and toilet use and had occasional incontinence of urine and frequent incontinence of bowel. The MDS listed the following diagnoses for Resident #54: Parkinson's disease, anemia, and hypertension. The MDS indicated Resident #54 fell twice with non major injuries since admission or the previous assessment. A review of the Electronic Health Record (EHR) revealed a progress note dated 9/8/18 at 5:24 AM that documented Staff H RN (Registered Nurse) and Staff G LPN (Licensed Practical Nurse) were called into Resident #54's room by Staff I CNA (Certified Nursing Assistant). Upon entering the room Resident #54, staff witnessed lying on the floor on her back. During interview on 9/11/18 at 2:50 PM Staff H stated she was paged to Resident #54's room. When she entered the room, Resident #54 lay on her back on the floor with a goose egg on the left side of her head. During interview on 9/11/18 at 3:50 PM Staff G stated she got a page from Staff I to come to Resident #54's room. When she arrived with Staff H, she noted Resident #54 lay on the floor on her back. When she looked at Resident #54 had a raised area on her left forehead and a skin tear on her left hand. During interview on 9/12/18 at 11:30 AM Staff I stated when she entered room the morning Resident #54 fell, she found her face down. Staff I stated she turned Resident #54 onto her back before the nurses arrived. Staff I stated Staff G informed her that a nurse needs to assess a resident prior to being moved. She also stated the DON (Director of Nursing) educated her on not	F 684		

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F 684	Continued From page 24 moving a resident after a fall without a nursing assessment being completed first. During interview on 9/13/18 at 8:20 AM, the DON stated staff should not move a resident after a fall until a nurse has completed an assessment. Review of an education form dated 9/10/18 revealed the following: Education for fall and safety. This education was provided verbally on 9/10/18 via phone after interview regarding Resident #54's fall. Staff I will ensure that a resident moves as little as possible by providing the resident with reassurance, encouraging deep breaths, offering touch therapy until the nurse arrives to assess. Staff I agreed to this education via the phone and reported to the DON that she would sign on her next shift. Review of general orientation information that the DON provided on 9/12/18 at 1:45 PM revealed the following information is given during orientation of all staff: What do I do when a resident falls, do not leave the resident, use your walkie to call for assistance, do not move the resident, a nurse must assess prior to any movement. Do provide reassurance to the resident while waiting for assistance.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		9.4.18

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F 689	Continued From page 25 accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of facility orientation guidelines and staffing education, the facility failed to prevent a fall for 1 of 2 residents reviewed for falls (Resident #54). The fall resulted in a fracture to the base of Resident #54's left second toe. The resident complained of dizziness right before staff assisted her to the commode, had a high risk for falls and was left unattended on the commode. The facility reported a census of 57 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 8/20/18, Resident #54 had a Brief Interview of Mental Status (BIMS) score of 13, indicating no cognitive or memory impairment. The MDS listed Resident #54 required the assistance of one staff for bed mobility, transfers, and toilet use and had occasional incontinence of urine and frequent incontinence of bowel. The MDS listed the following diagnoses for Resident #54: Parkinson's disease, anemia, and hypertension. The recorded Resident #54 fell twice with non major injuries since admission or the previous assessment. Review of the care plan revealed Resident #54 required assistance with dressing/undressing of one person. The care plan recorded that at times she will not wait for assistance and transfer herself from the bed and/or wheelchair or vice versa making her a risk for falls. The care plan listed the following interventions: soft touch call light started on 9/11/18, commode height reviewed and updated as needed to suit	F 689		

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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 689	Continued From page 26	F 689		

resident's height started on 9/10/18, non-skid strips placed in front of bedside commode started on 9/10/18, keep her wheelchair next to her bed with the brakes locked started on 9/4/18, non-skid strips next to her bed started on 8/29/18, encourage the resident to use gripper socks or non-skid footwear when walking started on 8/26/18 and she is OK with supervision while in the bathroom started on 5/25/18. Resident #54 had a history of dizziness, giddiness and weakness.

Review of fall risk assessment dated 8/21/18 revealed Resident #54 scored a 21; a score of 10 or higher represents a high risk for falls. A falls prevention program is listed as a referral for this resident. A nurse's note at the bottom of the form reads: fall risk assessment completed with a score of 21. She is at risk due to her immobility, incontinence, Parkinson's, and hypertension diagnoses. She is on a diuretic and on several medications for her hypertension.

A review of the EHR revealed the following progress notes:

a. 8/14/18 at 9:28 AM - Resident #54 continued to complain of dizziness and continued to state that the PRN (as needed medication, Meclizine) does nothing. The resident felt awful and when asked what exactly is wrong, she stated everything.
b. 8/16/18 at 10:22 PM - Resident #54 stated she felt horrible. Staff addressed the resident's dizziness and pain with PRN medications on this shift; both medications were ineffective.
c. 8/21/18 at 12:47 PM - Quarterly Review: she needs assistance of one with transfers and toilet use. There have been times when she took herself to the bathroom. She frequently complains

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 689	Continued From page 27 of dizziness and currently received 3 different medications for hypertension. The resident has had a significant drop in her blood pressure before receiving medication up to an hour after. Her primary physician wanted for her to see a cardiologist, but the family does not think it is necessary. She could put her light on and ask for assistance. d. 8/21/18 at 10:23 PM - Resident #54 received PRN medication for complaints of dizziness (Ativert) and the medication was not effective. e. 8/23/18 at 9:58 PM - She continued to be dizzy constantly; medication not effective. f. 8/25/18 at 9:49 PM - Resident #54 got up for about 30 minutes before wanting to be laid back down in her bed. Her blood pressure measured 180/78, she complained of being unbearably dizzy. Staff administered a PRN medication and it was not effective. g. 8/26/18 at 10:23 PM - At 5:00 AM, a CNA (certified nursing assistant) paged for a nurse who noted Resident #54 sitting on the bathroom floor, with her knees bent and head and shoulder leaning against the wall. A CMA (certified medication aide) stated Resident #54 tripped over her walker and she lowered Resident #54 to the floor. h. 8/28/18 at 10:35 PM - Resident #54 ate her dessert for supper and wanted to be put back into her bed immediately; she would have no oral care completed or to use the bathroom. Staff administered a PRN medication for dizziness and two Tylenol for pain. i. 8/29/18 at 3:33 AM - Staff witnessed Resident #54 falling to the floor as she entered the room. Resident #54 landed on her right side and hit her head on the floor, resulting in a half-dollar sized bump on the side of her head. j. 8/29/18 at 9:19 AM - Resident #54 complained	F 689		

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F 689	Continued From page 28	F 689		

of dizziness per her normal; staff administered PRN Meclizine but is not effective. This had been discussed multiple times with family as well as physician.
k. 9/1/18 at 12:35 AM - A CNA reported she observed Resident #54 on her knees with her head in the seat of her wheelchair and yelling for help. Staff noted no injuries.
l. 9/4/18 at 10:08 PM Resident #54 would not put forth any effort in helping staff with transfers; she required total assistance from two with a gait belt. Two staff had difficulty transferring the resident into her wheelchair to be taken to the restroom or out to eat in the dining hall, because of her lack of any effort to help with transfers.
m. 9/7/18 at 10:45 - While walking past the resident's room, staff heard a noise, looked inside and found Resident #54 on the floor with her head under the sink and feet at the toilet. She had her brief pulled up but her pants were still down. Resident #54 had been educated beforehand when placing her on the toilet, to hit the red button on her call light. When found, Resident #54 lay on the floor, holding her head and smiling. The resident stated 'I guess you didn't get here fast enough'.
n. 9/8/18 at 5:24 AM - Staff H RN (Registered Nurse) and Staff G LPN (Licensed Practical Nurse) were called into Resident #54's room by Staff I CNA. Upon entering the room, staff witnessed Resident #54 lying on the floor on her back. Staff I stated that Resident #54 was sitting on the bedside commode, stood up and fell forward onto the floor and hitting her head. Resident #52 had a 4.5 centimeter (cm) in diameter hematoma to her left lateral forehead and a 4 cm skin tear to the back of her left hand. Staff applied a cold pack to her head, cleansed the skin tear and applied 6 steri-strips, Telfa and

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F 689	Continued From page 29	F 689		

Kerlix secured with tape. Resident #54 was awake and alert, with her pupils active and reactive to light and equal hand grasps, range of motion within normal limits and no abnormalities no rotation noted. All proper notifications made, intervention implemented: Education to CNA.
o. 9/8/18 at 9:00 AM - Resident #54 complained of pain to her left foot with weight bearing. Staff noted swelling to her left foot, tender with inversion. Resident #54 could flex and dorisflex her foot without pain. Staff received an order for an X-ray of her left foot and ankle.
p. 9/8/18 at 11:30 AM - Staff re-assessed the resident's pain level. She denied pain and rested in bed. Staff noted decreased swelling in left foot and waited for the X-ray to be completed.
q. 9/8/18 at 5:00 PM - X-ray results recorded a fracture base of left second metatarsal (the long bone to the top of foot). Staff received an order to transfer resident to the emergency room.
r. 9/8/18 at 10:05 PM - Staff received a call from the emergency room nurse; they are sending her back to the facility. Resident #54 had a head CT scan that was negative. Resident #54 would return with a post-surgical boot to her left foot. She is minimal weight bearing and can transfer. Resident #54 should remain minimal weight bearing until follow up appointment.
s. 9/8/18 at 10:45 PM - Resident #54 arrived back to facility around 9:20 PM.
t. 9/12/18 at 10:09 AM - Resident #54 showed increased weakness and lethargy and her neurological assessment fell within normal limits. Resident #54 will verbally respond when she chooses to and complained of dizziness but this is per her normal. As needed (PRN) Meclizine is not effective when used and resident does not wish to have it at this time when asked. Staff assisted her using two person assist and a pivot

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 689	Continued From page 30 transfer with use of a gait belt. The Radiology Report of 9/8/18 documented Resident #54 had a fracture involving the base of the left second metatarsal (the long bone on the top of a foot) with modest displacement. Review of Event Reports revealed the following falls for Resident #54: a. 8/26/18 at 5:00 AM - Staff found her on the bathroom floor without the proper footwear on. b. 8/29/18 at 11:55 PM - She fell in her room; the resident did not want to wait for assistance and did not wear gripper socks. c. 9/1/18 at 12:35 AM - Resident #54 did not use her call light to ask for help to the bathroom. d. 9/7/18 at 5:45 PM - She did not use her call light to ask for assistance. e. 9/8/18 at 4:00 AM - Resident #54 attempted to stand up from the commode and fell forward Video footage viewed on 9/8/18 with the Administrator and DON present revealed the following: a. 9/8/18 at 3:49 AM - Staff I entered Resident #54's room and left at 3:54 AM. b. 9/8/18 at 4:01 AM - Staff I entered Resident #54's room and left at 4:02 AM. c. 9/8/18 at 4:03 AM - Staff I entered Resident #54's room. d. 9/8/18 at 4:05 AM - Staff G and H entered Resident #54's room. During an interview on 9/11/18 at 2:30 PM, Staff I stated Resident #54's call light went off, she answered it and the resident stated she needed to go to the bathroom. With a gait belt, she transferred her to the commode. Staff I stated she heard another resident yell for help, so she	F 689		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 689	Continued From page 31 told Resident #54 that she would be right back. When she returned Resident #54 was on the floor. Staff I stated Resident #54 wore a gait belt, secured under her breasts and outside of her shirt. Staff I stated Resident #54 has been having dizzy spells where she will grab right above her eyes and state she is light headed and dizzy. When asked if Resident #54 was dizzy the morning she fell, Staff I stated she said the resident stated she felt dizzy before Staff I got her on the commode. Staff I stated she was maybe out of the room for 2-3 minutes and the commode was positioned next to the bed so she could do a stand and pivot transfer with her. Staff I stated Resident #54 did not have care plan directions for supervision while on the commode. Staff I stated she found Resident #54 face down on the ground. Once she entered the room and found Resident #54 on the floor, she panicked then called for the nurses on her walkie talkie. When asked if there was anything she could have done different, she stated she should have called someone else to go help the other resident that yelled for help. During interview on 9/11/18 at 2:50 PM, Staff H RN stated she received a page about 4:00 AM to go downstairs. She walked into Resident #54's room and the resident lay on her back on the floor with a goose egg on the left side of her head. Staff H stated Resident #54 has a history of self-transferring. Staff H stated staff is to be in the room with Resident #54 if she is on the toilet or commode because she is at high risk for falls. Staff H stated Staff I told her that she went to help another resident calling out for help and when she returned she found Resident #54 on the floor. Staff H stated Resident #54 had a gait belt on.	F 689		

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

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F 689	Continued From page 32 During interview on 9/11/18 at 3:50 PM, Staff G LPN stated she got a page from Staff I to come to Resident #54's room. When she arrived with Staff H, she noted Resident #54 on the floor on her back. When she looked, Resident #54 had a raised area on her left forehead and a skin tear on her left hand. During interview on 9/11/18 at 4:20 PM, when asked to see the fall prevention program listed on the incident (event) report sheet, the Director of Nursing (DON) stated they do not utilize that anymore. They would rather come up with individual interventions rather than utilize a program that gives generic interventions. During interview on 9/12/18 at 8:50 AM, Staff F LPN stated Resident #54 complained of dizziness for a long time. Her primary doctor knows about these dizzy episodes and had requested a cardiology consult but the family did not want to move forward. Staff F stated Resident #54 just started using the commode recently. When Staff F assists Resident #54 to the toilet, she always stays with her because of her frequent falls and complaints of being dizzy. During interview on 9/12/18 at 9:00 AM, when asked what the facility does for residents deemed at high risk for falls, the DON stated they make sure the slip strips are in place, Resident #54 has gripper socks, the wheelchair is kept next to her bed with the brakes locked and non-slip footwear is being utilized when ambulating. She stated after the fall they started to utilize a soft touch call light. When asked what interventions need to be in place due to Resident #54 not wanting to wait for help, she stated they are trying to keep the environment safe for her as staff cannot be in	F 689		

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F 689	Continued From page 33	F 689		

everyone's rooms when they are in the bathroom. When asked what she would do if a resident felt dizzy and on the toilet, she stated she can put on the care plan not to leave her but it would be unrealistic for staff to stay when there are other demented residents that need help. She stated this would be setting her staff up to not follow care plans. The DON was given a scenario of a resident complaining of being dizzy but needing to use the toilet and asked if she would put that resident on the toilet and leave, she diverted back to not wanting to put on the care plan for Resident #54 to be supervised while on the toilet. It was then reiterated that if a resident was dizzy and needed the bathroom, would she put them on the toilet and leave knowing they were dizzy? The DON stated she would not leave the resident alone and would call for assistance if she needed to leave the room. When asked of the education given to Staff I after Resident #54 fell, she stated Staff I received education on the use of the walkie talkies to get help when assisting another resident.

During interview on 9/12/18 at 11:00 AM with Staff J CMA/CNA stated she always worked downstairs. When working with Resident #54 she stated she always stays in the room with her while she is on the toilet or commodes because she will self-transfer. Staff J stated Resident #54 likes her privacy so she will stay in the room and pull the privacy curtain or shut the bathroom door. Staff J stated Resident #54 will push her call light and if staff is not there within seconds, she will get up on her own. When asked what she would do if she was in the room with Resident #54 and another resident called out for help, she stated she would get on her walkie talkie and ask for assistance. Staff J stated Resident #54

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F 689	Continued From page 34 complains about being dizzy a lot and has been for a while now. During interview on 9/12/18 at 2:34 PM, Staff L CNA stated about two weeks ago, Resident #54 required assistance of 2 staff and a gait belt for transfers. Staff L stated he stays in the room when Resident #54 sits on the toilet or commode. When asked why he stays in the room, he stated because she has a high risk for falls and a tendency to lean forward when sitting up and that is when she falls. During interview on 9/12/18 at 2:45 PM, Staff K LPN stated Resident #54 required 1-2 staff for transfers for the last 2 weeks and had to be within sight of staff while up on the toilet or commode. Staff K stated in July she required 1 staff for transfers and that she used to complain of dizziness but not so much anymore. Review of education form with a date of 9/10/18 revealed the following: Education for fall and safety provided verbally on 9/10/18 via phone after interview regarding Resident #54's fall. In the future Staff I will contact a team member for assistance via walkie for another person to assist residents while assisting a person with a fall risk to the bathroom or the commode. Staff I agreed to this education via the phone and reported to the DON she would sign it on her next shift.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		9-21-18

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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F 758	Continued From page 35 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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F 758	Continued From page 36	F 758		

drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility failed to have the primary physician review the use of a psychotropic medication within 14 days of the start date, that was ordered on an as needed basis for 3 of 3 residents (#10, #25, and #46) reviewed. The facility reported a census of 57 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 6/11/18, Resident #10 had a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The MDS listed Resident #10 had diagnoses that included Alzheimer's disease, dementia, anxiety and depression. The MDS indicated Resident #10 received a daily antidepressant medication.

Review of Resident #10's care plan with an edit date of 8/27/18 revealed Resident #10 has dementia with behavioral disturbances, anxiety, major depression, and will frequently have delusions of her family being unsafe or waiting for her outside. The following approaches are listed on the care plan for staff to follow: when she is agitated or confused she will yell, hit and kick at team members. She is not easily redirected when she has delusions. Occasionally, she will refuse cares. Resident #10 usually become anxious about her children, staff is to provide reassurance they are safe. Staff are to offer her one to one when she is having delusions, to provide

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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 758	Continued From page 37 reassurance that she is safe with a goal of redirection. When Resident #10 becomes agitated, please offer her a quiet environment. Review of Resident #10's Medication Administration Records (MAR) revealed an order for Ativan (antianxiety) 0.5 milligrams (mg) every day as needed (PRN) with an origination date of 1/29/18. The following is a list of when this PRN order was used between March and September: a. March 12 times; b. April 12 times; c. May 1 dose given and it was discontinued on May 26; d. June 21 the order was restarted and moved to twice a day (BID) with a stop date of 1/2/19, but not used during the month of June; e. July, August, and September the order has not be used A Note to the Attending Physician/prescriber with a medication regimen review on 6/24/18 documented that changes to regulations require that all PRN medications be evaluated after 14 days by the physician or prescriber to determine the appropriateness of continued use. The resident currently has an order for Ativan 0.5mg BID PRN for anxiety. The order was restarted on 6/21/18. This medication has certain requirements that must be followed in order for the facility to remain in compliance. The primary care physician checked to continue the order because of anxiety and signed it on 7/2/18. The primary care physician reviewed this order 28 days after the start date when it is required to be reviewed within 14 days of the start date. Record review did not reveal another medication regimen review after the review on 7/2/18.	F 758		

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F 758	Continued From page 38 2. According to the MDS assessment of 9/3/18, Resident #46 had a BIMS score of 14, indicating no cognitive impairment. The MDS documented the resident had diagnoses that included stroke and hemiplegia. The assessment documented the resident received antipsychotic medication for 7 days, antianxiety medication for 2 days and antidepressant medication for 7 days during the review period. Review of Resident #46's care plan, with an edit date of 9/12/18, revealed she will frequently yell out, refuse to eat and cry. The care plan documented Resident #46 is not easily redirected. Review of Resident #46's MAR revealed the following order: Ativan 0.5 mg BID (twice a day) PRN with a start date of 8/9/18 and stop date of 12/6/18. Review of Resident #46's MARs revealed the Ativan PRN order used 17 times in August and twice in September. A Physician Communication and Order form dated 8/9/18 documented the resident's family visited and they requested an order for Ativan BID. The primary care physician ordered Ativan 0.5mg BID PRN A Note to the Attending Physician/prescriber with a medication regimen review on 8/28/18 recorded that changes to regulations require that all PRN medications be evaluated after 14 days by the physician or prescriber to determine the appropriateness of continued use. The resident currently as an order for Ativan 0.5mg BID PRN	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 758	Continued From page 39 for anxiety. The resident has utilized this order several times since prescribing on 8/9/18. Do you feel that it is appropriate to continue this order? The primary care physician checked to continue the order because it is still needed as documented. The primary care physician signed the form on 9/7/18, 19 days after the start date when it is required to be reviewed within 14 days of the start date. During interview on 9/13/18 at 8:20 AM, the Director of Nursing (DON) stated typically if the PRN medication is not used in 90 days, they will ask for an order for it to be discontinued. She stated she could not find any other 14 day reviews for Resident #46. The DON stated she will be this issue up in their Quality Assurance meeting. 3. The MDS assessment dated 6/29/18 identified Resident # 25 had impaired short and long-term memory and severely impaired cognitive skills for daily decision making. The MDS identified the resident had diagnosis of Non-Alzheimer's dementia and no behavioral symptoms. The MDS recorded the resident took antianxiety and antipsychotic medications during the previous 7 day look-back period. The care plan revised on 9/6/18 documented the resident had dementia. The interventions instructed staff to administer medication as ordered, offer reassurance when he became anxious, encourage deep breathing to relax and rest, and offer to walk with the resident when he asked or he stated things repetitively. The Physician Communication and Order Form dated 7/4/18 and signed by the physician on 7/5/18, included an order for lorazepam 0.5	F 758		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 758	Continued From page 40 milligrams (mg) orally (PO) every six hours (q 6 hrs) PRN. A note to the attending physician from the pharmacist dated 8/29/18 revealed lorazepam 0.5 mg q 6 hrs PRN for anxiety continued for a duration of 3 months due to continued behaviors. Staff noted the order on 9/7/18. The physician orders date 8/1/18 revealed lorazepam 0.5 mg q 6 hrs PRN. The medication administration record (MAR) dated July, August, and September 2018, revealed lorazepam 0.5 mg PRN administered on 7/4, 7/9, 7/12, 7/14, 7/16,8/12, 8/15, 8/16, 8/22, 8/23, 8/25, 8/26, 9/8, 9/20/18. In an interview 9/13/18 at 8:24 AM, the DON reported when PRN antianxiety such as Ativan (or lorazepam) is ordered, the medication needed reviewed by the prescribing provider or physician after 14 days to determine if medications needed continued or discontinued. At 9:47 AM, the DON stated she could not find any other documentation which pertained to Resident #25's PRN lorazepam, other than the initial order dated 7/4/18, and the review for PRN lorazepam sent to the physician by the pharmacist on 8/29/18. The DON reported she planned to follow up with the physician.	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 804	Continued From page 41 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and review of resident council meeting notes and facility policy, the facility failed to serve and maintain food temperatures for all entrees served to residents during the lunch meal service on 9/11/18 and failed to ensure resident room trays delivered in a timely manner to ensure food hot and palatable. The facility reported a census of 57 residents. Findings include: 1. During observation on 9/11/18 at 12:37 PM, Staff P, Dietary Cook, stated she had served the last plate of food for residents in the downstairs Dining Room. Staff P checked the temperature of the remaining food in the warming cart, which revealed the following temperatures: a. Meatballs - 115 degrees (F) (Fahrenheit) b. Pureed pork chop - 118 degrees (F) c. Pureed rice - 131 degrees (F) At 12:55 PM, the last resident had been served in the upstairs dining room. At 12:57 PM, a Certified Nursing Assistant (CNA) pushed a cart with room trays from the upstairs Dining Room to the middle hallway and delivered the meal tray to residents in Room 224 and Room 228. At 1:00 PM, Resident #13 stated to the CNA who delivered her room tray 'I thought you were never going to bring me lunch today'. At 1:03 PM, after Resident #13 had been served a meal tray, the	F 804		9-14-18

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 804	Continued From page 42 surveyor took the test tray from the food cart and checked the food temperatures. The food temperatures revealed the following: a. Pork chop - 136 degrees (F) b. Squash - 130 degrees (F) The pork chop and squash were lukewarm when tasted by the surveyor. In an interview 9/11/18 at 1:19 PM, Resident #13 reported she couldn't eat the food brought on a room tray, because she couldn't tell what it was and the food not hot. The resident reported meal trays came later and later and she wondered if she'd ever receive her food. In an interview, 9/12/18 at 12:55 PM, the Dietary Manager reported she expected food temperatures maintained at 140 degrees (F) or greater when served, 2. Ding observations on 9/10/18 revealed the following: At 12:29 PM, room trays plated for the residents upstairs. Dietary staff covered the bowls and plates with foil and placed each tray into a gray cart. At 12:33 PM, dietary staff plated a pureed diet, covered the plate with foil, and placed the tray in a gray cart. At 12:35 PM, the last resident received food in the upstairs dining room. At 12:40 PM, the Dietary Manager checked the gray cart with food trays parked in the hallway by the upstairs dining room, then walked down the hall and asked Staff R, Licensed Practical Nurse, if had any aides available, as room trays needed delivered. At 12:42 PM, a CNA delivered room trays to residents in rooms 224, 230, 231, and 228. At 12:52 PM, observed the gray cart parked in the hallway by room 222, still had room trays inside. A staff person sat on the bed and	F 804		

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

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F 804	Continued From page 43 assisted a resident in room 228 and fed the resident. In an interview, 9/12/18 at 12:55 PM, the Dietary Manager reported she expected room trays delivered to resident rooms as soon as room trays are plated. The Dietary Manager stated they had a CNA assigned on each level to deliver room trays. The Dietary Manager reported on 9/11/18 lunch trays had not been delivered right away. She tried to locate the CNA, but the CNA unable to pass the meal trays due to in a room and assisted a resident. The Dietary Manager reported residents complained about meal trays not hot for a few months, but the meal temperatures had gotten better. In an interview 9/13/18 at 8:24 AM, the Director of Nursing (DON) reported the residents nearest to the upstairs dining room got room trays served directly from the dining room, but other residents in the middle hall and the opposite hallway of the dining room had meal trays delivered in a cart. The DON expected CNAs to deliver those room trays to residents within a reasonable amount of time so food is hot when the resident received the meal tray. In an interview 9/10/18 at 2:15 PM, Resident #2 reported food is not hot. The resident reported she got some meals served in her room and some in the dining room. In an interview 9/10/18 at 11:39 AM, Resident # 26 reported she received most of the meals in her room and food not hot. In an interview 9/10/18 at 3:25 PM, Resident #50 reported food is not always hot when served.	F 804		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 804	Continued From page 44 The Resident Council meeting notes dated 4/9/18 and 5/4/18 revealed residents had complained about cold food, especially room trays. In a policy titled "Food Temperatures" revealed temperatures should be taken periodically to ensure hot foods stay above 140 degrees (F) during the portioning, transporting, and serving process until received by the resident. All hot food items needed served at a temperature of at least 120 degrees (F) at the time the resident received the food.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 812		10-4-18

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 812	Continued From page 45	F 812		

facility failed to perform proper hand hygiene while assisting residents with their meals. The facility reported a census of 57 residents.

Findings include:

Observation on 9/10/18 at 12:15 PM revealed Staff C CNA (Certified Nursing Assistant) assisting Resident #12 with her lunch by feeding her. Staff C scooped up some mashed potatoes on a spoon; she got some mashed potatoes on her hand then wiped it on the resident's clothing protector. While feeding Resident #12 her lunch, Staff C handled her cell phone then continued to assist Resident #12 with lunch. She did not sanitize her hands before touching the serving utensils. Staff C also touched her face multiple times during her time assisting Resident #12 and again never sanitized or washed her hands between tasks.

Observation on 9/11/18 at 8:30 AM revealed Staff C assisting Resident #32 with his breakfast by feeding him. Without sanitizing her hands Staff C then assisted Resident #48 by removing the plastic wrap from his drinking cups. Staff C moved her hair behind her ear and moved Resident #48's bowl while feeding Resident #32; she did not sanitize her hands between these tasks. Staff C then helped position Resident #48's nosey cups (after he had touched them) so he could drink from them, then went back to feeding Resident #32 without using hand sanitizer between tasks.

Observation on 9/11/18 at 12:21 PM revealed Staff C had assisted Resident #5 with her lunch by feeding her then assisted Resident #32 by feeding her without sanitizing her hands between

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 812	Continued From page 46 tasks. Staff C then assisted Resident #33 by pushing her wheelchair closer to table and went back to assist feeding Resident #32 his lunch. Observation on 9/11/18 t 12:29 PM revealed Staff C touched her face with right hand then handed Resident #32 a glass of water with the same hand, grabbing at the rim of the glass. Staff C did not sanitize her hands after she touched her face and failed to handle his drinking cup without touching the drinking surface. Staff C then handled her pager and continued to feed Resident #32, failing to use hand sanitizer. During interview on 9/13/18 at 8:20 AM, the Director of Nursing (DON) stated they do not have a policy related to preventing cross contamination while serving food. The DON stated she would expect staff to sanitize or wash their hands if they touch their face, hair, pagers and cell phones. She stated they should have their cell phones out during meal service.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		10-11-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 880	Continued From page 47 §483.80(a)(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; §483.80(a)(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. (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.	F 880		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 880	Continued From page 48 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 clinical record review, observations and staff interview, facility staff failed to practice effective hand hygiene during incontinent cares for 1 of 3 residents observed for cares (#46) and while emptying a catheter drainage bag for 1 of 4 residents observed with a catheter (#26) and failed to ensure sanitary oxygen tubing for 1 resident (#58). The facility reported a census of 57 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 9/3/18, Resident #46 had a Brief Interview of Mental Status (BIMS) of 14, indicating no cognitive impairment. The MDS indicated Resident #46 required the assistance of 2 staff for bed mobility and toilet use and experienced frequent urine and bowel incontinence. The MDS listed Resident #46 had diagnoses that included atrial fibrillation, urinary tract infection, retention of urine and hypertension. Review of Resident #46's care plan revealed no	F 880		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 880	Continued From page 49 information regarding her hygienic needs and any required assistance. Observation on 9/11/18 at 11:55 AM Staff A Certified Nursing Assistant (CNA) and Staff B CNA assisted Resident #46 with a brief change as she had been incontinent of urine. Staff A provided cares to the front side, removed her gloves and put on a new pair of gloves without performing hand hygiene such as sanitizing or washing her hands. Staff B assisted the resident to roll onto her left side and with the same gloves, she provided cares to the back side. After Staff B completed incontinent cares, she pulled the brief out, removed her gloves and got a new brief and new gloves. She did not sanitize her hands between tasks. Staff assisted the resident to put on a new brief. During a staff interview on 9/13/18 at 8:20 AM the Director of Nursing (DON) stated she expects staff to perform hand hygiene between clean and dirty tasks. 2. The MDS assessment dated 7/2/18 recorded Resident #26 had diagnoses that included diabetes, thyroid disorder and neuromuscular bladder dysfunction. The MDS indicated the resident required the assistance of one staff for toilet use and required an indwelling urinary catheter. The care plan dated 9/19/12 revealed the resident had a stroke and a flaccid neuropathic bladder. The care plan indicated the resident had an indwelling catheter but provided no staff direction regarding catheter care or management of the catheter.	F 880		

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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 880	Continued From page 50 The pocket care plan (for direct care staff) revealed Resident #26 had a catheter. During observation on 9/12/18 at 2:10 PM, Staff M, CNA placed an empty graduate container on top of a paper towel on the floor by Resident #26's recliner. Staff M washed her hands, donned a pair of gloves and removed a leg strap around the resident's left leg. Staff M drained urine from the catheter bag into the graduate container, cleaned the catheter port with an alcohol swab and sat the graduate container full of urine on a paper towel on the floor. Staff M removed her gloves, attached the catheter strap around the resident's left leg, then took the graduate container filled with urine into the bathroom without gloves on. Staff M had no gloves on when she emptied the urine into the toilet. Staff M then filled a small cup with water, poured the water into the graduate container, rinsed the graduate container and emptied the contents into the toilet. Staff M placed the empty graduate container into a plastic bag and sat the bag on the floor by the toilet. Staff M then washed her hands. In an interview 9/13/18 at 8:24 AM, the Director of Nursing stated she expected staff to wear gloves anytime they came in contact with urine or body fluids. The Staff Performance audit for Emptying a Catheter revealed the following procedural steps: a. assemble equipment and supplies b. wash hands and apply gloves c. place a paper towel on the floor underneath the drainage bag d. remove the drain tube and open the drainage bag clamp	F 880		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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GLEN HAVEN HOME	302 SIXTH AVENUE GLENWOOD, IA 51534

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F 880	Continued From page 51 e. close the drain when container emptied f. cleanse the opening on the catheter with an alcohol wipe g. replace the drain tube into the holder h. measure the output i. empty the container, then discard the container j. remove gloves and wash hands. 3. The MDS assessment dated 8/2/18 recorded Resident #58 had diagnoses of atrial fibrillation, Alzheimer's disease and vascular dementia without behavioral disturbances. The MDS revealed the resident had a brief interview for mental status (BIMS) score of 10 out of 15, which indicated moderately impaired cognition. The assessment documented Resident #58 experienced shortness of breath and received oxygen therapy. The care plan dated 7/27/18 recorded Resident #58 had atrial fibrillation, shortness of breath and needed oxygen. The care plan directed staff to apply oxygen per the physician's orders. The monthly infection control tracking form dated 7/2018 and 8/2018 revealed Resident #58 had an URI (upper respiratory infection) and took an antibiotic from 7/26 to 7/27/18 and from 8/7 to 8/16/18. During observation 9/10/18 at 11:04 AM, Resident #58 self propelled her wheelchair down the hall using her feet/legs. A portable oxygen tank hung on the back of the wheelchair and had an oxygen tubing attached to the tank. The oxygen nasal cannula and tubing drug on the floor behind the resident as she maneuvered her wheelchair the distance from her room to the mid-hallway area, approximately 50 feet. Staff M, CNA, stopped the	F 880		

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	165530	A. BUILDING _____ B. WING _____	09/13/2018

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

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F 880	Continued From page 52 resident in the hall, picked the oxygen tubing up off the floor, applied the oxygen cannula to the resident's nares (nostrils) and wrapped the tubing over the resident's ears. Staff M did not sanitize the tubing after it lay on the floor. In an interview 9/10/18 at 11:25 AM, Staff M confirmed she placed the oxygen cannula on Resident #58 when she found the resident wheeling down the hall without her oxygen tubing on. Staff M reported she set the oxygen gauge at 2 liters and ensured the portable tank had oxygen in it. In an interview 9/13/18 at 8:24 AM, the DON reported she expected staff replaced supplies, such as oxygen tubing, after it had dropped on the floor. The DON acknowledged she saw the CNA pick oxygen tubing off the floor and placed on Resident #58 on 9/10/18.	F 880		

F 758 Free from Unnec Psychotropic Meds/PRN Use

1. Resident #10 lorazepam was reviewed by the prescribing physician and have been discontinued on 9-21-18. Residents' #25 and #46 Lorazepam orders reviewed by the prescribing physician and were discontinued 9-14-18.
2. All current residents have had their orders reviewed and all PRN Lorazepam orders have been discontinued at this time. Psychoactive/Behavior Policy has been reviewed and revised as applicable.
3. All new psychoactive orders will be reviewed in the daily clinical standup in order to ensure care plans adequately address the necessary care approaches.
4. Any compliance issues will be reported monthly to the QAPI committee.

F804 Nutritive Value/Appear, Palatable/Prefer Temp

1. Pre-service temperatures met all temperature requirements. Post-meal temperatures of food not meeting standards was not served to any resident.
2. On 9-13-18 the use of the holding cart for room trays was discontinued. Room trays are now to be served directly from the steam table as they are ready. Review of the serving cart revealed one of the wells does not heat reliably. Facility vendor has been unable to repair in the past therefore the dietary team was educated on 9-14-18 not to use that well for meal service. Glen Haven Team was educated by dietary team during meal service regarding the room tray delivery process since the change.
3. One audit per week will be completed on a test room tray by DM or designee After temps will be also be checked weekly by the DM or designee.
4. Any compliance issues will be reported to and monitored by the facility QAPI committee.

F 812 Food Procurement, Store/Prepare/Serve-Sanitary

1. Education was provided to the facility team regarding sanitation and cell phone while assisting residents during meal services on 10-4-18.
2. Dietary team will ensure availability of hand sanitizer for each table of assisted residents.
3. A Dining Room Audit tool was reviewed and revised. Leadership Team will monitor meal services for 5 meals/week.
4. Compliance issues and audit results will be reported to the monthly QAPI Committee Meeting.

F 880 Infection Prevention and Control

1. Team members E and N have been educated on the proper technique by facility nursing team for catheter care on 10-4-18
2. Education provided to nursing team members on proper catheter care techniques. 9-26-18
3. Catheter care protocol was reviewed and revised as applicable
4. Two catheter care competency testing per week times four (4) weeks; then two catheter care competency tests per month. Any compliance issues will be reported to and monitored by the facility QAPI committee.

F 684 Quality of Care

1. Staff I was provided verbal education on 9-10-18 to ensure that residents are moved as little as possible following a fall until a nurse can assess.
2. Education was provided to nursing team on September 14, 2018 regarding not moving a resident observed on the floor until a licensed nurse has assessed.
3. Facility will continue current orientation program with fall prevention and protocol education included. Facility will continue routine fall prevention per facility education process.
4. Any compliance issues will be reported to and monitored by the facility QAPI committee.

F 689 Free of Accident Hazards/Supervision/Devices

1. Team member I was counseled on 9-8-18 on resident safety by the charge nurse on duty at time of fall. Team member I was given verbal education on 9-10-18 by DON regarding reporting changes of condition and asking for assistance to avoid leaving resident alone.
2. Acute Changes of Condition Education was given to direct care staff on September 14, 2018. Facility residents were reviewed and assessed for the need for supervision during toileting. Care plans for residents identified were updated as needed by 9-14-18
3. Changes of condition are monitored by the IDT routinely during clinical standup meeting to ensure timely and adequate follow up.
4. Any issues will be reported to the QAPI committee monthly.

2. The facility nursing team was re-educated on 9-27-18 regarding behold notices. Additionally facility transportation drivers were also educated 9-14-18 on regulations related to provision of bedhold policy before or at time of transfer and documentation requirements. Bedhold Policy Notification Acknowledgement form availability was checked at the facility nursing clinic to ensure staff access. Additionally forms were added to facility transportation vans to ensure access if resident transfer occurs from physician or other appointments.
3. Bedhold policy was added to the facility Discharge/Transfer Protocol. Resident Services or designee will audit all resident transfers to ensure compliance with Notice of Bed Hold Policy and documentation requirements.
4. Any compliance issues will be reported to and monitored by the facility QAPI committee.

F656 Develop/Implement Comprehensive Care Plan

1. Resident #25 Lorazepam 0.5 mg every six hours as needed was discontinued on 9-14-18. Care plan has been reviewed and revised as applicable.
2. Facility reviewed all current care plans of residents using psychoactive and revised as applicable to ensure compliance and side effect monitoring was addressed. Care Plan Policy was reviewed and revised. Education on the updated care plan policy was provided on October 4, 2018 during facility All Team All new psychoactive orders will be reviewed in the daily clinical standup in order to ensure care plans adequately address the necessary care approaches.
3. Any compliance issues will be reported monthly to the QAPI committee.

F657 Care Plan Timing and Revision

1. Care plan for resident #26 was revised to include catheter cares 9/28/18. Care plan for resident #46 was updated on 9/13/18 to include non-pharmacological interventions for behaviors prior to PRN medications administered.
2. All active residents with indwelling catheters care plans were updated to include catheter cares on 9/28/18. All active residents with anxiety or behaviors were also reviewed and revised as needed 9-28-18. Care plan policy reviewed and revised as applicable. Team will be re-educated on revised care plan policy on 10-4-18. Daily clinical standup
3. Five care plans audits will be completed per month by the Care Plan team to ensure timely revisions/directives/interventions are included.
4. Any compliance issues will be reported to and monitored by the facility QAPI committee.

F658 Services Provided Meet Professional Standards

The following constitutes Glen Haven Home's response to the regulatory deficiencies noted from the inspection completed 9/13/18. 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 4th, 2018

F622 Transfer and Discharge Requirements

1. Residents #2, #34 and #50 had already returned to the facility.
2. Discharge/Transfer Protocol was developed to include standardized medical information to be sent/provided at time of resident/patient transfer.
3. Team members were educated on 10-4-18 on the Discharge/Transfer Protocol. Review of all transfers or discharges will be completed during Clinical Stand up process to ensure Discharge/Transfer Protocol was followed.
4. Issues with compliance will be report to and monitored by facility QAPI committee.

F623 Notice Requirements Before Transfer/Discharge

1. Residents #34 and #42 have returned to the facility.
2. All discharge reports that were sent to the State Long Term Care Ombudsman Office office were reviewed to ensure inclusion of hospital discharges. July was the only month found not to include this discharge type. July Discharge Report was resent to the Ombudsman office on 9-12-18 during the survey visit.
3. Residents Services will request review of Discharge report by Administrator or designee prior to monthly submission of facility discharge information to the State Long Term Care Ombudsman Office to ensure all necessary information is included. The Administrator or designee will sign the cover sheet to document review. Resident Services and Administrator or designee will sign the form prior to sending to the Ombudsman.
4. Issues with compliance will be report to and monitored by facility QAPI committee.

F625 Notice of Bed Hold Policy Before/Upon Transfer

1. Residents 2, 34 and 50 had all returned to the facility by the time of survey. All are Medicaid beneficiaries whose beds were held during hospitalization per facility policy.

Julian Mallett
Administrator
10-5-18

1. Facility provided education for Staff A, B, and M regarding hand hygiene during catheter care and incontinent care. Staff M was educated on the sanitary use of oxygen tubing. All were completed by 10-4-18.
2. Facility performed competencies for nursing team members on hand washing, sanitary use of oxygen tubing, and proper catheter care including emptying of the catheter by 10-4-18.New Hire competencies will be completed for new direct care nursing staff prior to end of training period.
3. Facility will perform hand hygiene/incontinence audits three (3) times per week. Catheter care audits will be completed 1 time per week. Facility nursing leadership will observe oxygen tubing handling during weekly nursing rounds.
4. Compliance issues will be reported monthly to the QAPI Committee.

Compliance Date 10-4-18