STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 6/03/19 An investigation of Complaint #80881-C, Complaint #82607-C, Complaint #82887-C and Self Report #82886-I completed on 5/7/19 resulted in the following deficiencies. Complaint #80881-C was not substantiated. Complaint #82607-C was substantiated. Complaint #82887-C was substantiated. Self Report #82886-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, facility staff failed to provide adequate privacy during incontinent care for 1 of 3 residents (Resident #13). The facility reported a census of 46 residents. Resident #3's face sheet with a print date of 4/24/19 documented diagnoses of Alzheimer's disease, incontinence of feces and urinary incontinence. A Minimum Data Set (MDS) with an assessment reference date of 3/28/19 indicated the resident needed total assistance of 2 staff for incontinent care. A staff assessment for mental status indicated severe cognitive impairment. During an observation dated 4/23/19 at 11:40 a.m. Staff K, a certified medication aide (CMA)	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 550	Continued From page 2 and Staff L a certified nursing assistant (CNA) entered the residents room and closed the door and privacy curtain. Upon entry the three window blinds had been raised and the resident could be seen from the outside when cares were given. Staff gloved, checked the resident for incontinence and reported the resident was incontinent of both feces and urine. Staff initiated incontinent care by removing the resident's incontinent briefs and cleansing the resident's genitals and inner thighs. Staff stopped the procedure to retrieve additional washcloths; leaving the resident's genital exposed and not covered. Staff returned and completed the care. During an interview dated 4/23/19 at 12:05, Staff L CNA reported no concerns regarding the incontinent care given to Resident #3. When she was asked if there were any privacy concerns during this care she reported the resident's door was closed and privacy curtain drawn. When asked about the open window blinds, she reported she would close the window blinds so the resident would have total privacy. During an interview dated 4/24/19 at 11:40 a.m., the director of nursing stated she expects staff to provide privacy when completing personal cares. Staff are to close the resident's door, privacy curtain and window blinds if open.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 558	Continued From page 3 other residents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to provide bottled oxygen for four of four residents (Resident #4, #5, #6, #8 and #10), requiring them to use oxygen concentrators until the facility obtained liquid oxygen and portable oxygen bottles. The facility reported a census of 46 residents. 1. Resident #4's face sheet indicated he admitted to the facility on 3/26/19. Diagnoses included a history of pneumonia, multiple fractures of ribs to left side and unspecified atrial fibrillation. Hospital discharge instructions dated 3/26/19 documented the resident was hospitalized for a fall and rib fracture, acute hypoxia, atelectasis and new onset atrial fibrillation. An order summary report with a print date of 4/16/19 indicated continuous oxygen (O2) therapy 2 to 3 liters per minute (lpm) via nasal cannula (NC). Progress notes dated 3/30/19 at 7:38 a.m. documented staff reported the resident in pain. The resident appeared short of breath with purple nail beds. The resident's respirations were at 44 breaths per minute and oxygen saturation rate (SpO2) at 85% on room air. Oxygen applied at 2 lpm via NC. Staff notified resident's physician who directed staff to transport the resident to hospital emergency room (ER) for evaluation/treat for acute respiratory distress. Progress notes dated 3/30/19 at 9:21 a.m. documented staff from local hospital ER notified facility staff the resident would return to the facility. The resident's SpO2 levels were at 96% on 2 lpm per NC and respirations were down to	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 558	Continued From page 4 28. Facility staff called the on call registered nurse (RN) to obtain transportation back to the facility. Hospital discharge orders dated 3/30/19 included continuous oxygen therapy at 2 lpm via NC. 2. Resident #5's face sheet with a print date of 4/16/19 documented diagnoses of chronic obstructive pulmonary disease (COPD) and chronic kidney disease. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 1/18/19 indicated a Brief Interview for Mental Status (BIMS) of 9. A score of 9 indicated moderate cognitive impairment. An order summary with a print date of 4/16/19 indicated a physician's order dated 4/26/18 for continuous O2 at 2 lpm via NC. 3. Resident #6's face sheet with a print date of 4/16/19 documented Resident #6 with diagnoses of chronic systolic heart failure, Parkinson's disease and urinary incontinence. An MDS with an ARD date of 3/22/19 indicated a BIMS score of 14. A score of 14 indicated normal cognition. An order summary report with a print date of 4/16/19 documented a physician order dated 1/25/19 for O2 2-5 lpm by NC daily every 12 hours as needed. 4. Resident #8's face sheet with a print date of 4/16/19 documented Resident #8 with diagnoses of COPD. An MDS with an ARD date of 2/5/19 indicated a BIMS score of 6. A score of 6 indicate severe cognitive impairment. An order summary report with a print date of 4/16/19 documented a physician's order dated 1/23/19 for continuous O2 at 2 lpm via NC. 5. Resident #10's face sheet with a print date of	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 558	Continued From page 5 4/16/19 documented Resident #10 with diagnoses of bradycardia, heart failure and atrial fibrillation. An MDS with an ARD date of 2/21/19 indicated a BIMS of 5. A score of 5 indicated severe cognitive impairment. An order summary report with a print date of 4/16/19 documented a physician's order dated 1/14/19 for continuous O2 at 2 lpm via NC. During an interview dated 4/16/19, the director of nursing reported Staff A called 3/30/19 reporting all three (3) liquid O2 tanks were empty. Resident #4 went to the local hospital ER due to a health decline. The resident returned the same day and no O2 cylinders were available. Staff used an oxygen cylinder designated for hospice residents for the resident even though Resident #4 was not a hospice patient. She reported she called the facility's office manager the same day who reported the liquid oxygen vendor hadn't been paid and the company had stopped delivery. During an interview dated 4/23/19 at 6:12 a.m., Staff B, RN reported Resident #4 returned from the hospital on 3/30/19 with orders for continuous O2. She went to fill a portable O2 cylinder from the liquid O2 tank but there wasn't any. An oxygen cylinder for hospice residents was used to transport the resident back to the facility. O2 concentrators were used exclusively the afternoon of 3/30/19 and 3/31/19 until two hospice agencies delivered O2 cylinders the afternoon of 3/31/19. Residents were brought to the dining room in groups of two as the concentrators had to be plugged into a wall outlet and were a trip hazard. During an interview dated 4/24/19 at 9:06 a.m. Staff H, a certified medication aide (CMA)	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 558	Continued From page 6	F 558		

reported she worked the weekend of 3/30/19-3/31/19. The facility didn't have portable oxygen cylinders available for residents and oxygen concentrators were used both days, which limited their mobility. Residents were brought out in groups of two due a tripping hazard related to the power cords and having only two electrical outlets available.

During an interview dated 4/24/19 at 9:10 a.m., Staff A, a registered nurse (RN) reported Resident #4 was sent to a local hospital ER for evaluation and treatment for acute respiratory distress. The resident returned to the facility with a physician's order for continuous O2 at 2 lpm via NC. Staff went to the hospital to transport the resident back to the facility. A hospice O2 bottle was taken from storage for use by the resident as the facility had no other O2 available. She reported the facility was out of liquid O2. Three (3) bottles of O2 belonging to hospice residents remained but this inventory was used by staff for residents the remainder of 3/30/19. Staff had to use oxygen concentrators for Resident's #4, #5, #6, #8 and #10 in lieu of portable O2 cylinders during all meals for the remainder of 3/30/19 - 3/31/19 until the afternoon of 3/31/19 when two hospice agencies replenished inventory. Staff A reported she contacted the facility's supplier of liquid O2 but the vendor reported they would not be supplying oxygen until the bill owed was paid.

An email received from the vendor dated 4/18/19 at 11:01 confirmed a past due balance. The email indicated delivery of liquid oxygen stopped on 3/8/19 due to a credit hold dated 3/6/19 when liquid O2 had been delivered. Delivery of liquid O2 resumed on 4/3/19 when the facility submitted a partial payment of the balance due. The vendor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 558	Continued From page 7 agreed to extend payment terms to the facility. The two hospice vendors reported via email that deliveries were made on 3/31/19.	F 558		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to administer medications in accordance to physician orders and manufacturer's directions 4 of 6 residents reviewed. Observation of 44 medications adminstered revealed 7 errors resulting in a 15.9% error rate (Resident #16, #17, #19 and #20). The facility reported a census of 46 residents. Resident #16's face sheet with a print date of 5/1/19 documented diagnoses of dysphagia, cerebral infarction due to thrombosis of cerebral artery, hemiplegia and hemiparesis. Medication Review Report, with a print date of 5/1/19 documented Cyanocobalamin (vitamin) tablet 400 micrograms (mcg) 2 tablets in the morning, Sertraline (antidepressant) 50 mg - 1 tablet in the morning, Finasteride Tablet (for urinary retention) 5 milligram (mg) 1 tablet every morning, Multivitamin Adults tablet 1 tablet in the morning. An observation of a medication administration pass dated 5/1/19 at 7:00 a.m., Staff J, a certified medication aide (CMA) removed the above medications from each medication bubble pack	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 759	Continued From page 8	F 759		

and placed them in a medication cup. Staff began to crush medications when she was asked where the physician's order to crush the resident's medication. A review of the MARs and Medication Review Report dated 5/1/19 revealed no order to crush these medications.

Resident #17's face sheet with a print date of 5/1/19 documented diagnoses of peripheral vascular disease, polymyalgia rheumatically and sciatica. Medication Review Report, with a print date of 5/1/19 documented Levothyroxine sodium capsule (thyroid) 100 mcg - 1 tablet in the morning. An observation of a medication administration pass dated 5/1/19 at 7:40 a.m., Staff J administered the above medication to the resident. During an interview dated 5/1/19 at 7:50 a.m. the resident reported she already ate breakfast.

Resident #19's face sheet, with a print date of 5/1/19 documented diagnoses of amnesia and adjustment disorder. Medication Review Report, with a print date of 5/1/19 documented Levothyroxine 25 mcg - 1 tablet in the morning. An observation of a medication administration pass dated 5/1/19 at 9:07 a.m., Staff T, CMA administered the above medication to the resident. An interview with Staff T at the conclusion of the medication pass reported the resident had already ate breakfast prior to the administration of his medication.

Resident #20's face sheet, with a print date of 5/1/19 documented diagnoses of altered mental status, alcohol dependence and syncope and collapse. Medication Review Report, with a print date documented Levothyroxine 50 mcg - 1 tablet in the morning. An observation of a medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 759	Continued From page 9 administration pass dated 5/1/19 at 7:15 a.m. J, administered the above medication to the resident. The resident, after the medication had been administered went directly to the dining and ate his breakfast. During an interview dated 5/2/19 at 10:21 a.m., the director of nursing stated Levothyroxine needs to be given at 1 hour before breakfast. Staff can administer this medication beginning at 6:00 a.m. The facility's policy for Medication Administration from Cart with an origination date of 5/1/08 directed staff to crush medications if ordered by the resident's physician. The reference guide used by staff and located in the nurse's station was Nursing 2017 Drug Handbook which identified on page 875, that Levothroxine sodium should be administered at the same time each day on an empty stomach preferably 1/2 to 1 hour before breakfast	F 759		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, hospital records, physician and staff interviews, the facility failed to administer medication to 1 of 9 residents (Resident #15) as ordered by her physician resulting in the resident becoming non-responsive and required hospitalization. The physician reported the medication overdose caused harm to the resident. The facility reported a census of 46 residents.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 760	Continued From page 10 Resident #15's face sheet, with a print date of 4/26/19 documented diagnoses of Alzheimer's disease, unspecified psychosis not due to a substance or known physiological condition and atrial fibrillation. A Minimum Data Set with an assessment reference dated 3/19/19 documented a Brief Interview for Mental Status score of 7. A score of 7 indicated moderate cognitive impairment. Progress notes dated 4/25/19 at 8:39 a.m. documented Staff O, a registered nurse (RN) notified the resident's physician of the resident's little response to staff this morning, breathing irregularly and staring at the ceiling. The resident's heart rate was 110 beats per minute (bpm). The physician responded on 4/25/19 at 11:09 a.m. and ordered to hold Zyprexa "for now." Progress notes dated 4/25/19 at 2:45 p.m. revealed an aide could not arouse the resident. Staff P, RN noted the resident lying in bed and unresponsive even with physical stimulation. Staff P called emergency medical services (EMS) and the resident was transported to a local hospital emergency room for evaluation/treatment. During an interview dated 4/30/19 at 6:46 a.m. Staff R, a certified nursing assistant (CNA) reported the morning of 4/25/19 she went to the resident's room around 8:00 a.m. The resident wasn't her normal self. Routinely she would call for assistance to the bathroom. Staff R would assist her with dressing, personal hygiene and would assist her to her chair and assist her with her hearing aids. This morning the resident had a hard time staying awake and had difficulty opening her eyes. Staff O, RN was called to the	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 760	Continued From page 11	F 760		

room and directed staff to allow the resident to stay in bed for a couple of hours, as the resident had a history of becoming lethargic and less responsive when there are medication dosage changes. Staff R reported the resident stayed in bed for most of the morning. Around 1:00 p.m. she tried to wake the resident but she wasn't opening her eyes. She rolled the resident to one side and her breathing sounded labored. She rolled her back and tried to wake the resident with no response. Staff J, a certified medication aide (CMA) came into the room and then left to get Staff P, RN.

Hospital Information:

Hospital emergency department record/history and physical dated 4/25/19 at 2:03 p.m. documented an assessment of altered mental status due to possible unintentional overdose of Zyprexa. The onset/occurrence identified as 2 hours earlier with symptoms coming on suddenly. The severity of symptoms were severe and the patient was currently unresponsive. Hospital disposition notes dated 4/25/19 at 4:52 p.m. indicated the resident admitted to the hospital for close monitoring due to mental status changes. It would likely take a few days to resolve the mental status changes due to the medication having a relatively long half-life, the resident's age and other medical problems. It was not appropriate for the patient to return to the nursing home due to the need for very close observation.

Physician Interview:

During a phone interview dated 4/29/19 at 9:10 a.m., the resident's attending hospital physician reported the resident suffered harm and required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 760	Continued From page 12	F 760		

hospitalization for treatment of the Zyprexa overdose. He confirmed the resident was not responsive when she arrived at the hospital.

Zyprexa Error:

An incident report dated 4/25/19 at 9:30 a.m. documented the resident received Zyprexa 5 mg on 4/16/19. The medication administration record (MAR) read to give two tablets Zyprexa 2.5 mg. Staff administered Zyprexa from the original bubble pack of Zyprexa 2.5 mg - 1 tablet at bedtime due to late delivery of Zyprexa 5 mg. Staff placed the bubble pack card of Zyprexa 5 mg in the cart in error and failed to remove the discontinued Zyprexa 2.5 mg - 1 tablet at bedtime. The incident report noted the resident unresponsive and eyes fixed.

A medication review report with a print date of 4/16/19 revealed a new physician order to increase Zyprexa 2.5 milligrams (mg) - 1 tablet by mouth at bedtime to Zyprexa 5 mg to administer after supper. Medication Administration Records (MARs) documented Zyprexa 2.5 mg - 1 tablet at bedtime was discontinued 4/16/19. Zyprexa 2.5 mg - 2 tablets at bedtime, with a start date of 4/16/19 was added to the MAR. Pharmacy delivered a new card of Zyprexa the evening of 4/16/19 with the Zyprexa 5 mg. dosage in each slot of the new card. Staff did not write the new order "Zyprexa 5 mg. after supper" on the MAR, which was the dose the card contained and what the physician ordered. Instead the MAR continued to read "Zyprexa 2.5 mg. 2 tablets at bedtime" Staff signed on the MAR they administered Zyprexa 2.5 mg - 2 tablets at bedtime 4/16/19-4/24/19. Staff A, RN initialed she administered Zyprexa (2) 2.5 mg 4/18/19,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 760	Continued From page 13 4/19/19 and 4/22/19, Staff N, RN initialed she administered Zyprexa (2) 2.5 mg 4/16/19, 4/17/19, 4/20/19, 4/21/19 and 4/24/19. Staff M, RN initialed she administered Zyprexa (2) 2.5 mg 4/23/19 and 4/25/19. Observation of the Zyprexa 5 mg drug card revealed pills were removed from the Zyprexa 5mg card daily 4/17/19 through 4/24/19. Observation of the Zyprexa 2.5 mg drug card showed 2.5 mg daily doses were removed from that card during the same time frame 4/17/19 through 4/24/19. This indicated the resident received medications from both cards in error. During an interview dated 4/30/19 at 11:10 a.m., Staff Q, a licensed practical nurse (LPN) reported when she learned the resident was unresponsive she checked the resident's medication in the bubble packs and noted Zyprexa 2.5 mg - 1 tablet at bedtime had been removed for dates 4/16/19-4/24/19. Zyprexa 5 mg - 1 tablet after supper had been removed 4/17/19-4/24/19, which indicated the resident recieved 7.5 mg 4/17-4/24/19. She reported her findings to the director of nursing (DON). During an interview dated 4/29/19 at 8:05 a.m., the director of nursing confirmed the resident received Zyprexa 7.5 mg from 4/17-24/19. She also reported that two medication errors occurred specific to the original order for Zyprexa 2.5 mg - 1 tablet at bed time and the new order of Zyprexa 5 mg. - 1 tablet after supper. The first medication error occurred when staff administered Zyprexa 2.5 mg on 4/16/19 and not Zyprexa 5 mg - 1 tablet after supper. The second error occurred when staff erred and administered both the Zyprexa 2.5 mg and Zyprexa 5 mg	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 760	Continued From page 14 4/17/19-4/24/19 totalling 7.5 mg. Staff interviews with staff who administered the wrong doses of Zyprexa: During an interview dated 4/29/19 at 10:05 a.m. Staff A, RN reported she is not certain what she had done. Either she gave the wrong dosage of Zyprexa or she hadn't. She reported she didnt documented giving 2.5 mg - 1 tablet of Zyprexa but she had documented giving Zyprexa 5 mg. During an interview dated 4/29/19 at 10:30 a.m. Staff N, RN reported she was not certain how much Zyprexa she administered to the resident. She reported when there is a medication order change that staff usually removed the discontonued drug card from the medication cart. In this incident both Zyprexa 2.5 mg that was discontinued remained in the cart alongside the Zyprexa 5 mg. During an interview dated 4/30/19 at 10:00 a.m. Staff M, RN reported she had worked 4/23/19 and again on 4/25/19. She reviewed the MARs for both dates and confirmed she had initialed 4/23/19 and 4/25/19 as giving the resident her Zyprexa but she reported she wasn't certain what dosage of Zyprexa she gave. She couldn't explain why she had initialed 4/25/19 when the resident was no longer in the facility. The facility abated the immediate jeopardy on May 7, 2019 after the facility reeducated staff on new medication administration protocols. The facility also conducted visual audits of staff administering medications after they received education regarding new protocols.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 835	Continued From page 15	F 835		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the administration and governing board failed to provide an operating budget, staff and services to provide for the needs of residents residing in the facility. The facility reported a census of 46 residents. During an interview dated 4/15/19 at 3:00 p.m., the Administrator reported the facility has a past due balance with vendors who supply necessary goods and services related to resident care. The Administrator provided a list that included current and past vendors in addition to balances the facility believes it owes. A list of vendors included staffing agencies, respiratory services, the facility medical director, food service, pharmacy, medical suppliers, telephone, information-technology, water and electric companies and call light systems in addition to ancillary vendors. On 4/16/19 the Administrator supplied a list of vendors along with pending invoices and past due balances. Thirty one (31) vendors were contacted to verify balances owed by the facility. Vendors reported past due balance of $594,417.70. The facility provided bank records dated 4/1/19-4/17/19 which revealed a past due mortgage balance of $599,766.39. The	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 835	Continued From page 16 Administrator reported the facility has two separate accounting systems it currently uses. She reports she is uncertain of the actual amount owed to vendors. Of the 31 vendors contacted 7 vendors who provided essential services for resident care reported they would no longer provide services to the facility until the past due amounts or payment arrangements were made by the facility. One vendor reported they would provide limited services to the facility.	F 835		
F 880 SS=D	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: §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,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 880	Continued From page 17 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. §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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 880	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to wash their hands prior to and after completing personal cares when administering medications for 4 of 4 residents (Resident's #2, #12, #13 & #18). The facility reported a census of 46 residents. 1. Resident #2's face sheet with a print date of 4/24/19 documented diagnoses of Muscular Dystrophy and muscle weakness. A Minimum Data Set (MDS) with an assessment reference date (ARD) dated 2/20/19 indicated the resident required extensive assist of 2 staff for transfer. The resident had occasional incontinence of urine. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14. A score of 14 indicated normal cognition. During an observation dated 4/23/19 at 11:50 a.m., Staff K, a certified medication aide (CMA) and Staff S, CMA assisted the resident with transfer from bed to his electric scooter. Staff used a Hoyer lift to transfer the resident. Once the resident was positioned in his electric scooter, Staff K removed her gloves and the left the room. Staff S positioned the resident's legs on the foot pedals, removed her gloves and washed her hands and left the room. Both Staff K and L did not wash their hands before entering the resident's room. Staff K left the resident's room without washing her hands. 2. Resident #13's face sheet with a print date of 4/24/19 documented diagnoses of Alzheimer's disease, incontinence of feces and urinary incontinence. A MDS with an ARD dated 3/28/19 indicated the resident needed total assistance of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 880	Continued From page 19 2 staff for incontinent care. A staff assessment for mental status indicated severe cognitive impairment. During an observation dated 4/23/19 at 11:40 a.m. Staff K, a certified medication aide (CMA) and Staff L, a certified nursing assistant (CNA) entered the residents room and closed the door and privacy curtain. Upon entry neither staff washed their hands before gloving and completing incontinent care. The facility's policy titled Perineal Care with a revision dated 3/1/14 directs staff to wash hands when entering the resident's room when providing perineal care. 3. During an observation of medication administration dated 5/1/19 at 8:05 a.m. Staff G, a certified medication aide (CMA) administered the medications to Resident's #12 & Resident #18. Staff G removed medications from bubble packs for each resident and dropped the medication into her open ungloved hand. She then placed the medications in a paper cup for each resident. During an interview dated 5/1/19 at 8:30 a.m. Staff G, CMA reported she has always pushed the tablet/pill from the bubble pack into her hand and then placed the tablet/pill into a medication cup. During an interview dated 5/1/19 at 9:15 a.m. the facility's director of nursing reported it was her expectation for staff to place medication from the bubble pack directly into a medication cup and not to touch the medication directly.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 919	Continued From page 20	F 919		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, the facility failed to provide a functional electronic call system for residents to call caregivers to assist them with their care needs. The facility reported a census of 46 residents. The facility's nurse call systemas described by vendor information is a wireless electronic system that provides full coverage by protecting residents anywhere in the facility. The system is designed to reduce response time of caregivers and documents call and response history. The facility provides the resident with a bracelet/pendent call button. Staff are notified when a resident activates the pendent. Staff receives a message via an iPod and laptop computer. An interview dated 4/16/19 at 11:10 a.m., the facility's maintenance director reported residents are given a pendent or bracelet to wear. The vendor who provides this system refuses to provide training to new staff or him with training on the system and will not provide any additional support or to fix damaged equipment due to a past due balance owed.	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 919	Continued From page 21 During a private meeting with residents on 4/17/19 at 10:30 a.m., residents reported they felt uncertain if their call pendants work, as staff do not respond to their calls for assistance. During an interview dated 4/23/19 at 10:40 a.m. Resident #2 reported he needed staff assistance with transfer and toileting. He reported he activated his call pendent on several occassions and waited longer than 40 minutes for staff to respond. He reported he felt physically uncomfortable waiting for staff. During an interview dated 4/23/19 at 9:55 a.m. Resident #3 reported she didn't want to get anyone into trouble but it takes staff a long time to respond to her calls for assistance. She reported it takes staff greater than 30 minutes for staff to assist her with cares. During an interview dated 4/23/19 at 9:35 a.m., Resident #6 reported it takes staff too long to respond to his calls for assistance. He reported he soiled himself waiting for someone to assist him with toileting. During an interview dated 4/23/19 at 9:22 a.m., Resident #11 reported many occasions when staff didn't respond to his call for assistance. He called to use the toilet and soiled himself waiting. Conversely, when staff assisted him to the toilet he waited as long as 35 minutes for staff to assist him off the toilet. This usually happened in the evening. During an interview dated 4/23/19 at 10:25 a.m. Resident #12 reported she called for assistance only to have staff come in her room, turn her call	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 919	Continued From page 22 light off and tell her they have to get another staff to assist. Staff didn't return for another 20 to 25 minutes, which means she has had to wait 40 minutes for staff to assist her. She reported she has had accidents soiling herself. An audit of the facility's call light response system dated of 3/1/9-4/22/19 with random dates within the date range revealed 472 calls that exceeded greater than 15 minutes for staff to respond. 123 of the 472 calls (26 %) exceeded 25 minutes before staff responded to a resident's call for assistance. On 4/23/19 at 8:30 a.m., the director of nursing reported at the time of the investigation that the call light system malfunctions. There are only two functional iPods for staff. The iPods alert the staff that a resident activated his/her call light. She strated the facility can't obtain new pendants for existing or newly admitted residents. She reports she and staff, including the maintenance director haven't been trained on the call light system. She reported the Wi-Fi network and the call light system goes down frequently. On 4/25/19 at 8:01 a.m. the maintenance director reported the system recently malfunctioned a couple of times. He hasn't had any technical support or additional hardware for months. Staff report the call light system crashes and the call light system will not operate. He reports residents have reported their call bracelet/pendent doesn't function. He reported he recently found out the facility had two operating devices (iPod) that notify staff of a resident calling for assistance. On 5/6/19 at 11:15 a.m. the maintenance director reported the facility's Wi-Fi system had connectivity problems with the call	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 919	Continued From page 23 light system. He reported he had to replace 10 Wi-Fi antenna in the last four years and replacing a Wi-Fi antenna in C-hall this past month. On 5/6/19 at 11:16 a.m. the call system representative arrived onsite and reported the maintenance director called on a couple of occassions seeking assistance when the call system has malfunctioned and he gave support on a limited basis. New staff, including the maintenance director haven't been trained on the call system. The facility received 42 iPods during the contract period but now only has two functional iPods. He reported the facility had problems with their Wi-Fi network. The last training provided to facility staff was 11/26/18. An email sent by the vendor representative 5/6/19 at 1:14 p.m. reported technical support services ended August, 2018. The last staff training on the call system occurred 11/26/17. On 5/7/19 at 11:00 a.m. the representative reported its unknown if staff knows they need to log into the call system during each shift change for the system to work properly.	F 919		

POC for Rowley Complaint Survey 5/07/19
Revised 6/03/19

Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements

F 550
Resident #13 had no negative outcomes

Staff have been re-educated on providing privacy during incontinent cares

Privacy audits will be conducted 3 times weekly for 4 weeks, then weekly for 2 months.

Audit trends will be brought to the facility QAPI committee for review and further recommendation.

The DON or designee is responsible for ensuring compliance.

Date certain: June 3, 2019

F558
Resident #4, #5, #6 and #10 had no negative outcomes

Education will be provided to staff on ensuring the proper amount of Oxygen is available for resident use.

Oxygen audits are being conducted 2 times weekly for 3 months. Delivery date of Oxygen is every Wednesday ongoing.

Audit trends will be brought to the facility QAPI committee for review and further recommendation.

The Administrator or designee is responsible for ensuring compliance.

Date certain: June 3, 2019

F 759
Resident #16, #17, #19, and #20 Medication Administration Record (MAR) have been reviewed and updated to ensure staff know who requires their medications to be crushed and medications that require to be given on an empty stomach.

Nurses and Certified Medication aide (CMA) have received education on who require medications to be crushed and medications that require to be given on an empty stomach. The Nursing Drug Books will be in each med cart to refer to for questions related to medications.

Medication audits will be completed weekly for 3 months

Audit trends will be brought to the facility QAPI committee for review and further recommendation.
The DON or designee is responsible for ensuring compliance.

Date certain: June 3, 2019

F 760
Resident #15 has been discharged from facility.

Immediate Plan of Correction for All Other Residents at risk for medication errors

All medications audited to ensure dosage available matches the written order for administration.

Any medication identified that does not match written prescription will be removed and identified to alert staff to review order before administration. (Dose on order matched dose on card)

Employee Training Plan for medication errors

Licensed and unlicensed staff administering medications will be educated on the need to follow the 6 rights of medication administration.

Licensed and unlicensed staff educated on the importance of accurate dose on the medication itself as well as the written order comparison.

Licensed staff educated on actions to take when dose of medication available does not match the written prescription.

Unlicensed staff educated on communicating to nurse supervisor if medication dose available does not match written prescription.

Licensed and unlicensed staff have been observed and medication administration competency confirmed through individual check off.

Education on addendum to nursing in-service on medication changes: If there is a dosage change to a medication, the nurse taking the order must ask the prescribing physician to initiate the dose the next day. The nurse then must document the conversation with the physician and pass it on in report.

When the dosage changes, the nurse then must to the medication cart and pull the medication (either bubble pack or whatever the medication is in)

Audits- Medication Errors

Audits of medication administration will be completed 5 times per week for 4 weeks and then two times per week for 4 weeks and then weekly for 4 weeks.

Audit trends will be brought to the facility QAPI committee for review and further recommendation.

The DON or designee is responsible for ensuring compliance.

Date certain: May 20, 2019

F 835
There are no Critical Vendors who do not provide services to the facility.

Critical vendors are communicated with routinely and kept apprised of any payment issues that arise.

Weekly review of AP is completed and vendor payments are prioritized by team of ED, RDO, Board President, Bank Partner and HDG Accounting.

Audits of outstanding balances and payment arrangements will be performed twice monthly for 3 months.

Audit trends will be brought to the facility QAPI committee for review and further recommendation.
The ED or designee is responsible to ensure compliance.

Date Certain: June 3, 2019

F 880
Resident #2, #12, #13, #18 had no negative outcomes.

Staff have be re-educated on proper handwashing techniques that include when to wash hands.
Handwashing audits will be conducted 5 times weekly for 4 weeks, then weekly for 2 months.

Audit trends will be brought to the facility QAPI committee for review and further recommendation.

The DON or designee is responsible for ensuring compliance.

Date certain: June 3, 2019

F 919:
Past Due balance has been paid in full and Service Contract has been signed with call light vendor.

Service Plan specifically covers software updates, on-site tech support & staff training, device repairs & replacement, and remote support.

Maintenance Director & ED have been trained to troubleshoot hiccups and train staff, access reports and work remotely with technical support.

Alternate signaling devices have been purchased in the event that the call light system malfunctions. Staff has been trained regarding location of alternate signaling devices and how to use/distribute in an emergency.

Call light reports 5 times weekly for 3 weeks, then 2 times weekly for 2 weeks, then weekly for 1 month.

Audit trends will be brought to facility QAPI committee for review and further recommendation.

ED or Designee is responsible for ensuring compliance.

Date Certain: June 3, 2019

6/26/2019: Addendum to F558 to include resident #8

F558
Resident #4, #5, #6 #8 and #10 had no negative outcomes

Education will be provided to staff on ensuring the proper amount of Oxygen is available for resident use.

Oxygen audits are being conducted 2 times weekly for 3 months. Delivery date of Oxygen is every Wednesday ongoing.

Audit trends will be brought to the facility QAPI committee for review and further recommendation.

The Administrator or designee is responsible for ensuring compliance.

Date certain: June 3, 2019

NHA Signature Lisa W. Eastman, MS ED **Date** 6/26/2019