DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165358 | A. BUILDING _____ B. WING _____ | 03/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THOMAS REST HAVEN | 217 MAIN STREET COON RAPIDS, IA 50058 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>Correction Date_4/10/20_____<br><br>The following deficiencies relate to the facility recertification survey and Investigation Facility Reported Incident #87329 and Complaint #88892<br><br>Facility Reported Incident #87329 was substantiated.<br><br>Complaint #88892 was substantiated.<br><br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | Please accept the following Plan of Correction as the facility's credible allegation of compliance. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(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).<br>(iii) Any specialized services or specialized | F 656 | F 656<br><br>Thomas Rest Haven ensures residents care plans are up to date to reflect their current needs. Resident #8 and #19 and all like residents have had their care plans reviewed and updated as needed to reflect their medication and care needs. Staff were educated on 3/31/2020 and MDS/Nurse managers were educated on 4/2/2020 re: the need to notify the DON/MDS Nurse regarding resident changes so that the resident care plan can be reviewed and updated accordingly. | 4/10/20 |

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

Administrator 4/10/2020

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.

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| F 656 | Continued From page 1<br>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)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to develop and implement a comprehensive person centered care plan for 2 of 14 residents reviewed, (Resident #8, and Resident #19). The facility reported a census of 39 residents.<br><br>Findings Included:<br><br>1. A Minimum Data Set (MDS), dated 3/4/20, revealed Resident #8 admitted to the facility on 2/27/19. The MDS identified the resident as independent with transfers and ambulation. Resident #8's diagnoses included: Parkinson's disease, dementia, hypertension (high blood pressure), depression, and osteoarthritis. According to the MDS, the resident scored 3 out of 15 on the Brief Interview for Mental Status | F 656 | DON and/or designee will continue to monitor for compliance on a weekly basis for 3 months. Concerns will be discussed and monitored by the QAPI Committee. | |

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(BIMS) test which indicated severe cognitive impairment.

A March 2020 Medication Administration Record (MAR) revealed Resident #8 received Warfarin (an anticoagulant) 1 milligram (mg) by mouth daily

Review of the care plan with a revision date of 3/1/20, revealed no active care plan in place for management of Resident # 8's warfarin use, nor did it list any side effects for the use of the medication.

On 3/17/20 at 5:20 p.m. the Director of Nurses (DON)on 3/17/20 at 5:20 p.m., DON stated the care plan should contain the information regarding warfarin use and side effects of the drug. The DON stated the facility hired a new care plan nurse and she would ensure an update to the care plan to include the warfarin use/side effects. The DON further stated that the facility did not have a policy on facility care plan processes.

2. A MDS dated 12/19/19, assessed Resident #19 with a BIMS score of 7, which revealed severe cognitive impairment. The resident's diagnoses included: malignant neoplasm of prostate, pulmonary (lung) hypertension (high pressure) and coronary artery disease. The MDS indicated the resident required extensive assistance of two staff for bed mobility, transfers, and toileting. The MDS identified the resident as always incontinent of bowel and bladder and no toileting plan.

Resident # 19's March 2020 MAR revealed the resident received Augmentin (an antibiotic)

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| F 656 | Continued From page 3<br>875-125 mg. 1 tablet twice per day and initiated on 3/3/20 and ended on 3/13/20. The resident also received Furosemide (a diuretic medication) 80 mg. once per day.<br><br>Review of laboratory (lab) reports for Resident #19 revealed a urine culture and sensitivity (C&S) lab report completed on a urine sample (UA) the facility sent to the lab on 2/28/20. The result of the C&S identified the resident with a urinary tract infection (UTI) and the organism causing the infection as Proteus Mirabilis. On 3/3/20, resident's physician wrote the order for the antibiotic to treat the UTI.<br><br>A care plan with revision date of 3/1/20 did not include the resident's urinary incontinence status or interventions to manage the incontinence. The care plan also failed to contain updates regarding the UTI or the use of the Furosemide or side effects of the drug.<br><br>On 3/17/20 at 5:10 p.m. the DON stated that Resident #19's care plan should contain information on urinary incontinence status, current urinary tract infection with antibiotic order, and use of Furosemide and side effects. The DON further stated that the facility did not have a policy on the facility care plan processes. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that | F 657 | | |

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| F 657 | Continued From page 4<br>includes but is not limited to-(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to review and revise the care plan for 2 of 14 residents reviewed, (Resident #20, and Resident #33). The facility reported a census of 39 residents.<br><br>Findings Included:<br><br>1. The Minimum Data Set (MDS) with assessment reference date of 1/27/20 revealed Resident #20 with a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired cognition. The resident required limited assistance of 1 staff for transfers, toileting and dressing. The MDS listed the resident admission | F 657 | F 657<br>Thomas Rest Haven ensures residents care plans are up to date to reflect their psychotropic medication care needs. Resident #20 and #33 and all like residents have had their care plans reviewed and updated as needed to reflect their psychotropic medication needs. Staff were educated on 3/31/2020 and MDS/Nurse Managers were educated on 4/2/2020 re: the need to notify the DON/MDS Nurse regarding resident changes so that the resident care plan can be reviewed and updated accordingly. DON or designee will continue to monitor for compliance on a weekly basis for 3 months. Concerns will be discussed and monitored by the QAPI Committee. | 4/10/20 |

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| F 657 | | F 657 | | |

Continued From page 5 date of 1/20/20. The resident's diagnoses included: high blood pressure, congestive heart failure, anxiety disorder, and depression.

Resident #20's March 2020 Medication Administration Record (MAR) revealed the resident received Sertraline (antidepressant) 200 milligrams (mg) daily, initiated on 1/20/20. The resident also received Buspar (antianxiety) 10 mg twice per day initiated 1/20/20.

Resident #20's current care plan revealed no documentation regarding the use of Buspar and Sertraline. The care plan failed to contain interventions related to the use of anti-anxiety medications and anti-depression medications and did not contain information regarding the possible adverse side effects with use of the medications.

On 3/17/20 at 5:46 p.m. the Director of Nurses (DON) on 3/17/20 at 5:46 p.m. confirmed the care plan did not contain the use of the Buspar and the Sertraline, and their side effects. The DON stated the facility hired a new care plan coordinator and she plan to work on the care plans to get them up to date. The DON also confirmed the facility did not have a policy or procedure for care-planning requirements.

2. A MDS dated 2/5/20, assessed Resident #33 with a BIMS score of 8, which indicated severe cognitive impairment. The MDS revealed the resident required extensive assistance of two staff for bed mobility, transfers, dressing and toileting. The resident's diagnoses included: anemia, Alzheimer's dementia, depression, and chronic obstructive pulmonary disease.

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| F 657 | Continued From page 6<br><br>Resident #33's March 2020 MAR revealed the resident received Sertraline (antidepressant) 100 mg daily initiated 6/11/19. The MAR also revealed the resident received Lorazepam (antianxiety) 0.5 mg once per day on Wednesdays and Saturdays, initiated on 1/14/20.<br><br>Resident #33's current care plan did not contain information regarding the use of Lorazepam and Sertraline. There care plan did not contain interventions related to the use of anti-anxiety medications and anti-depression medications and potential adverse side effects of the drugs.<br><br>On 3/17/20 at 5:46 p.m. the DON confirmed the care plan did not contain information regarding Sertraline or Lorazepam including side effects of the drugs. The DON stated the facility hired a new care plan coordinator and she plan to work on the care plans to get them up to date. The DON also confirmed the facility did not have a policy or procedure for care-planning requirements. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to properly follow physician's orders for administration of medication that resulted in a medication error and failed to follow physician's | F 658 | | |

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| F 658 | Continued From page 7 orders to obtain daily weights for 3 of 14 residents reviewed. (Resident #8, Resident #22 and Resident #20). The facility reported a census of 39 residents.<br><br>Findings included:<br><br>1. A Minimum Data Set (MDS), dated 3/4/20, assessed Resident #8 with a Brief Interview for Mental Status (BIMS) score of "3". A score of "3" identified severe cognitive impairment. The MDS identified the following indicators of delirium: disorganized thinking and inattention behaviors on a continuous, daily basis. The resident had diagnoses that included: Parkinson's disease, dementia, hypertension (high blood pressure), depression, and osteoarthritis.<br><br>The current care plan with a revision date of 3/1/2020 , revealed no care plan information regarding the resident's use of Coumadin (blood thinner).<br><br>Resident #8's March 2020 medication administration record (MAR) revealed he received Coumadin 1 milligram (mg.), 1 tablet daily on Sunday, Tuesday, Wednesday and Friday and Coumadin 2 mg. on Monday, Thursday, and Saturday.<br><br>Resident # 8's International Normalized Ratio (INR- blood test to determine how thin the blood is) flowsheet revealed the facility last checked the INR on 1/15/20 and with 2.4 result (within normal range). The INR flowsheet identified the next INR due on 2/14/20. There was no entry into the resident progress notes to indicate the resident had an INR test completed on 2/14/20. | F 658 | F 658<br><br>Thomas Rest Haven does provide cares and services according to accepted standards of clinical practice. Residents #8, #20 and #22 and all like resident's orders have been reviewed and staff are following physician's orders to include obtaining and documenting ordered labs and obtaining daily weights as ordered. Nursing staff were educated on 3/31/2020 and MDS/Nurse Managers were educated on 4/2/2020 re: obtaining and documenting ordered labs and the importance of obtaining daily weights as ordered. DON or designee will continue to monitor resident for compliance on a weekly basis for the next 3 months. Concerns will be discussed and monitored by the QAPI Committee. | 4/10/20 |

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A physician telephone order, received at the facility by a charge nurse on 1/15/20, revealed the physician stated the INR result was 2.4 and there would be no change in medication orders. The physician directed the facility to check another INR in 1 month.

Review of Resident #8's progress notes revealed no INR completed during the month of February 2020 as ordered.

Review of Resident #8's lab section of chart revealed no INR completed on 2/14/20 as ordered.

On 3/16/20 at 10:40 a.m. the MDS coordinator stated she could not find any record of a completed INR for Resident #8 during the month of February 2020. The MDS coordinator stated the laboratory did not always send a copy of the lab results to the facility.

On 3/17/20 at 5:27 p.m. the Director of Nursing (DON) revealed she knew the facility missed drawing Resident #8's INR during the month of February. The DON stated the facility is developing a plan to improve communication between the clinic and the nurses at the facility so the facility can track INR's better. The DON stated she expected the charge nurse to follow-up appropriately with the clinic to ensure the facility completes INRs on time. The DON further verified that the facility did not have a policy or procedure for obtaining INR labs for residents. The DON also confirmed there was no incident report filled out for the missed INR for the month of February 2020.

2. A MDS for Resident #22 with an Assessment

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Reference Date (ARD) of 1/27/20 showed a BIMS score of 11, indicating moderate cognitive impairment. The MDS identified the resident as independent with bed mobility, transfers, and toileting. The resident had diagnoses that included: atrial fibrillation (abnormal heart rhythm), coronary artery disease, and high blood pressure.

Resident # 22's care plan with a review date of 2/29/20 revealed a goal that the resident would take her anticoagulant as ordered without serious complications. The care plan directed staff to be aware of the risk for bleeding, report adverse side effects and observe the resident for active signs of bleeding such as bleeding from gums, nosebleeds excessive bruising. Staff will monitor lab work as ordered and notify the doctor of results. Adjust medication changes when ordered.

Resident #22's resident progress notes revealed on 1/19/20 a medication error occurred with the medication Coumadin (anticoagulant blood thinner). A signed physician order dated 1/16/20 directed staff to administer Coumadin 1.5 mg daily instead of the prior order order which was: alternate Coumadin 2 mg tab every other day with Coumadin 1.5 mg tab every other day. Resident progress notes revealed staff administered Coumadin 2 mg., instead of Coumadin 1.5 mg on 1/17/20 and on 1/19/20.

A facsimile (fax) to the physician dated 1/19/20, revealed staff updated the physician regarding the medication error that occurred on 1/17/20 and 1/19/20. The physician directed staff to continue to administer Coumadin 1.5 mg. daily and to check INR level in 2 weeks.

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On 3/17/2020 at 5:27 p.m. the DON stated she knew about Resident #22's medication error in February 2020. The DON stated the facility is developing a plan to improve communication between the clinic and the nurses at the facility so the facility is able to track lab orders better. The DON stated she expected the charge nurse to follow-up appropriately with the clinic to ensure physician orders are followed.

Review of the facility's undated Medication Errors and Drug Reactions Policy included the following information:
Purpose of policy-Establish uniform guidelines for reporting and recording of medication errors and drug reactions.
Procedure:
1. All medication errors and drug reactions must be promptly reported to the DON attending physician, pharmacist and/or the resident representative.
2. A detailed account of the incident must be recorded in the resident's medical record. The documentation should include. a. Time and date of incident.
b. Name, strength and dosage of medication administered.
c. Resident's reaction to the medication.
d. Condition of the resident
e. Any treatment administered.
f. Date and time the physician was notified and instruction/orders given.
3. Closely monitor the resident who has received incorrect medication or is having a drug reaction. Immediately report to the Director of Nursing and attending physician any change in resident condition. 4. Charge nurse is responsible for completing the

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Continued From page 11 incident report (separate from documentation in the resident's medical record) and submitting a copy to the DON and the administrator.

3. The MDS completed for Resident #20 with an ARD of 1/27/20 showed a BIMS score of 11, indicating moderate cognitive impairment. Per the MDS, the resident required limited assist of 1 staff with bed mobility, transfers, ambulation and toileting. The MDS listed diagnoses of hypertension (high blood pressure), congestive heart failure (CHF), anxiety, thyroid disorder and depression .

The care plan problem dated 2/4/20 stated Resident #20 had potential for weight fluctuations due to CHF, recent pneumonia and need for antidepressants. The care plan goal stated resident will not have a weight gain/loss greater than 5-10% of her baseline weight of 133#'s in the next 30-180 days. The interventions included- a. Staff to assess for signs of dehydration, b. Encourage oral intake. c. Monitor /record weight. Notify MD and family of significant weight change. d. Record intakes of food and fluids, e. Offer food substitutes f. Provide regular diet as ordered.

Review of Resident # 20's medical record revealed a new order dated 3/3/20 for staff to weigh the resident daily due to recent changes in medication. The physician further instructed staff to send the weight log sooner if there were any problems and to report any weight change greater than 3 pounds or any edema (swelling in extremities).

Review of Resident #20's weight record in

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| THOMAS REST HAVEN | 217 MAIN STREET COON RAPIDS, IA 50058 |

| (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 |
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| F 658 | Continued From page 12<br>Electronic Healthcare Record (EHR) revealed the facility did not complete weights on 3/5/20, 3/10/20, 3/14/20, 3/15/20 and 3/16/20.<br><br>On 3/17/20 at 5:27 p.m. the DON revealed the facility did not have a policy or procedure on weighing residents. The DON stated she expects the nursing staff to follow all physician's orders and the facility needs a better system in place to track daily weights. | F 658 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical review and interview the facility failed to assess edema for 1 of 15 residents reviewed (Resident #142). The facility reported a census of 39 residents.<br><br>Findings include:<br><br>A Minimum Data Set (MDS) dated 2/5/20, assessed Resident #142 with a Brief Interview for Mental Status (BIMS) score of 15. (no cognitive impairment). The MDS revealed the resident required limited assistance with the help of one person for bed mobility and toilet use and extensive assistance with the help of two for | F 684 | | |

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| F 684 | Continued From page 13 transferring and dressing. The resident had diagnoses that included: cellulitis of the lower limbs, pressure ulcer of the sacral region, acute respiratory failure and diabetes mellitus.<br><br>The baseline care plan dated 3/6/20, upon readmission after a hospitalization, the resident required assist of 2 and was totally dependent for bed mobility. The resident was totally dependent with transfers assist of 2 and for transferring and toileting.<br><br>A resident progress note dated 11/14/19 10:45 AM, revealed the resident initially admitted to the facility on 11/14/19 after a traumatic fall in the community with injury to the left shoulder. The resident discharged to home on 12/20/19 and returned to the facility on 1/3/20 on a court committal per his doctor and local authorities of the county as they felt he was not able to safely care for himself at home.<br><br>A resident progress note dated 1/5/20 at 11:25 AM revealed the resident transferred to the hospital due to shortness of breath and a low oxygen saturation, and he returned to the facility on 1/10/20. The resident progress note dated 2/24/20 at 10:00 AM revealed the resident's oxygen saturation dropped to 76% and he experienced another syncope episode. The facility notified the physician and the resident transferred to the hospital. He received diagnoses that included: pulmonary embolism and returned to the facility on 3/6/20. Physician orders upon return to the facility on 3/6/2020 included: apply lymphedema wraps to bilateral lower extremities every other day.<br><br>Observation showed on 3/10/20 at 9:20 AM the | F 684 | F 684<br><br>Thomas Rest Haven ensure residents receive treatments and care in accordance with professional standards of practice, comprehensive care plan and resident choices. Resident #142's care plan has been reviewed and updated. All other residents' care plans and orders were reviewed to ensure care plans are current and interventions/orders are being followed. Staff were educated on 3/31/2020 and MDS/Nurse Managers were educated on 4/2/2020 regarding following physicians care orders and treatment plans. DON and/or designee will continue to monitor/audit resident for compliance on a weekly basis for the next 3 months. Concerns will be discussed and monitored by the QAPI Committee. | 4/10/20 |

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| F 684 | | F 684 | | |

Continued From page 14

resident in the recliner wearing slip resistant ankle-high stockings and his feet resting on the floor. The resident did not wear any any edema wear or wrapping on his lower extremities. The resident used oxygen per nasal cannula at 4 liters. The resident's lower lower extremities appeared very edematous, his shins appeared bright pink and shiny with several reddened areas.

On 3/10/20 at 10:40 AM the resident was in the same position in his recliner with his feet on the floor. At 11:39 AM Staff J LPN (licensed practical nurse) entered the room to take a blood sugar reading. She did not offer to reposition the resident. At 12:02 PM the resident received lunch in his room and the resident sat in the same position with his feet on the floor. At 1:30 PM on 3/10/20 the resident sat in the chair with the foot feet on the recliner in the up position.

On 3/11/20 at 7:28 AM, Staff B CNA (certified nurse aide) stated before the resident went to the hospital he used Ace wrapping on his lower legs but she hadn't seen them wrapped since he returned to the facility on 3/6/20.

On 3/11/20 at 7:30 AM the surveyor asked Staff T RN (reregistered nurse) to pull off one of the resident's gripper socks and look at his feet. She agreed that his feet looked very swollen. The surveyor asked her to push her finger into the top area of his foot and rate the edema. Staff T did so and identified the resident with 4 plus edema.

On 3/11/20 at 9:55 AM and at 10:08 AM observation showed the resident in his wheelchair after a shower. At 10:28 AM staff wheeled the resident to the lobby and at 11:20

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| F 684 | Continued From page 15<br>AM staff brought the resident to his room still in his wheel chair, feet down, and no wrapping or edema wear to his lower extremities. The surveyor drew attention to the extent of edema in his feet and legs and Staff A CNA looked at his legs and feet and asked him if he would like to have them wrapped. The resident agreed, saying; "now that I've had my shower that would be okay."<br><br>On 3/11/20 at 1:30 PM observation showed the resident in his recliner with feet up but no edema wear. At 1:43 PM Staff H RN went into his room and offered him pain medicine, but no edema wear offered. At 3:16 PM the resident sat in the recliner with his feet on the floor and no wrapping.<br><br>On 3/12/20 at 6:45 AM the resident sat in the recliner with feet elevated and no edema wear. At 7:55 AM and 10:20 AM observation showed the resident in the recliner with his feet on floor. At 10:25 AM the surveyor asked Resident #142 if he remembered agreeing having leg wrapping applied to his legs and feet the day before and he said he did remember. The surveyor asked him if anyone offered to wrap his lower extremities yet that morning and he replied no and stated he would still agree to the wrappings.<br><br>On 3/12/20 at 10:35 AM the surveyor asked Staff H RN about the resident's edematous legs and feet and offering edema wear or wrapping. She responded that he refused earlier that morning. The surveyor asked Staff H to come to the resident's room. At 10:40 AM Staff H looked at his feet and asked him if he agreed to having the legs and feet wrapped. The resident agreed.<br><br>On 3/12/20 at 3:00 PM observation showed Ace | F 684 | | |

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| F 684 | Continued From page 16 wrapping on his feet and lower legs.<br><br>A review of the clinical chart revealed a physician's order dated 1/10/20, directing staff to provide daily weights for Resident #142. The chart lacked weights on 1/14, 1/17, 1/18, 2/21, 1/26, 1/28 and 2/2. The physician discontinued the order on 2/4/20. Review of the recorded weights revealed no recorded weight fluctuations more than 3 pounds. The resident did have a five pound increase in weight from 2/19/20 through 3/11/20 after his hospitalization. The chart lacked a weight upon readmission on 3/6/20.<br><br>On 03/12/20 at 11:58 AM, the Director of Nursing (DON) stated Resident #142 often refuses cares but she would check the notes to see if the nurses documented when he refused to have weights completed or refused edema wraps.<br><br>On 03/12/20 at 01:14 PM, the DON acknowledged the order for daily weights written on 1/10/20. She stated she could not find any documentation where the resident refused weights. She went on to say that the resident is very noncompliant. The DON said that due to staff conflicts many times the resident care and documentation is not as consistent as it could be. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure | F 686 | | |

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| F 686 | Continued From page 17<br>ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical review and interview the facility failed to provide the necessary care and services for pressure sores for 1 of 3 residents with pressure sores (Resident #142). The facility reported a census of 39 residents.<br><br>Findings include:<br><br>A Minimum Data Set (MDS) dated 2/5/20, assessed Resident #142 with a Brief Interview for Mental Status (BIMS) score of 15. (no cognitive impairment). The MDS revealed the resident required limited assistance with the help of one person for bed mobility and toilet use and extensive assistance with the help of two for transferring and dressing. The resident had diagnoses that included: cellulitis of the lower limbs, pressure ulcer of the sacral region, acute respiratory failure and diabetes mellitus.<br><br>The baseline care plan dated 3/6/20, upon readmission after a hospitalization, the resident required assist of 2 and was totally dependent for bed mobility. The resident was totally dependent with transfers assist of 2 and for transferring and toileting.<br><br>A resident progress note dated 11/14/19 10:45 AM, revealed the resident initially admitted to the | F 686 | F 686<br><br>Thomas Rest Haven ensures resident receives care consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless clinical condition demonstrates that they were unavoidable. Resident #142 and all like residents have current skin assessments in place. Current skin assessments and any ordered treatments are assessed on a weekly basis. Care plans have been reviewed to include skin prevention/maintenance interventions to aid in wound healing. Staff have been educated on 3/31/2020 regarding the importance to ensure care plan interventions are being followed and any new skin impairments are communicated to DON/Skin Nurse. | 4/10/20 |

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| F 686 | Continued From page 18<br>facility on 11/14/19 after a traumatic fall in the community with injury to the left shoulder. The resident discharged to home on 12/20/19 and returned to the facility on 1/3/20 on a court committal per his doctor and local authorities of the county as they felt he was not able to safely care for himself at home.<br><br>On 3/10/20 at 10:40 AM the resident was in the same position in his recliner with his feet on the floor. At 11:39 AM Staff J LPN (licensed practical nurse) entered the room to take a blood sugar reading. She did not offer to reposition the resident. At 12:02 PM the resident received lunch in his room and the resident sat in the same position with his feet on the floor. At 1:30 PM on 3/10/20 the resident sat in the chair with the foot feet on the recliner in the up position.<br><br>On 3/11/20 at 7:25 AM Staff B CNA (certified nurse aide) and Staff A CNA assisted the resident, with the help of the sit to stand lift, off of the commode into the recliner. Staff B wiped the buttocks of the resident and she noticed there blood. Staff B stated the resident would receive a shower that day and she would have the nurse check the residents bottom.<br><br>On 3/11/20 at 8:25 AM staff took the resident to the shower in his wheel chair. Once in the shower room, Staff B and Staff A transferred him out of his wheelchair with the sit to stand lift and left him upright while Staff P located the ulcer areas on his buttocks and measured them. The resident became easily fatigued and they allowed him to rest several times before completing the task. Staff P LPN measured the area on the upper right crease of his buttocks. She looked lower on the buttock close to the anus area and determined | F 686 | DON/Skin nurse will complete random audits on new admissions and on a weekly basis for 3 months to assess skin assessments and/or treatment needs and will ensure proper weekly assessments are completed and care plan interventions are in place. | |

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| F 686 | | F 686 | | |

Continued From page 19 the blood came from that area and identified it as a new open area. Staff P described it as on the right side of anus measuring 1 centimeter (cm) x 0.5 cm 0.2 cm depth. Staff P, LPN stated that she is the designated skin nurse assigned to observe and document wounds on Monday, Wednesday and Fridays.

On 3/11/20 at 1:30 PM the resident sat in his recliner with feet up but no edema wear. At 1:43 Staff H RN (registered nurse) went into his room and offered him pain medicine. At 3:16 PM the resident still sat in the recliner with his feet on the floor.

The 3/6/2020 baseline care plan identified a 1 centimeter (cm.) open area to the coccyx. The care plan directed staff to turn and reposition the resident and provide cushions or wedges. The care plan revealed a skin treatment for Calazine (skin protectant) for the buttock area.

Review of physician orders and medication administration records failed to identify a treatment order for the pressure sores or treatments signed for by staff.

A review of the clinical record revealed several documents used to monitor skin conditions and ulcers for Resident #142:
A Skin Condition Report dated 1/13/20 identified a spot on the "top of buttock crease" measuring 2.5 cm x 0.7 cm. The same sheet had an entry on 3/6/20 that documented only "1 cm" without specifying length or width.

A Pressure Ulcer Documentation initiated on 1/4/20 identified an area as "coccyx crease open area" that initially measured 4 cm x 2 cm. On

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| F 686 | Continued From page 20<br>3/11/20 under location and stage, and entry the area measured 2 cm x 2 cm x 1.5 cm slit.<br><br>Another Pressure Ulcer Documentation sheet started on 1/4/20 identified an area identified as: "top area open" and first measured at "0.5 x 0.5 x 0.1 depth, right buttock stage 3." On 1/29/20 another area was added to same sheet identified as mid right buttock 1.5 cm x 1 cm 0.1 cm depth. Another area was added to same sheet lower right buttock 2 cm x 2 cm x 0.1 cm On the same sheet, dated 3/11/20, under the location and stage column the entry stated "pink surrounding right & left" the documentation lacked a specific area. None of the documentation matched the new spot that Staff P described as "right side of anus 1 cm x 0.5 cm 0.2 cm depth" when she assessed the resident in the shower on 3/11/20.<br><br>On 3/16/20 at 3:30 PM, Staff P LPN stated she usually starts a new assessment sheet when a new pressure area is discovered. She agreed that the documentation could make it difficult to determine progress in healing.<br><br>The clinical chart lacked a Braden Skin assessment and complete skin assessment upon the resident's readmission to the facility on 3/6/20. A Braden Skin assessment was added to the chart on 3/17/20, which identified the resident at risk for pressure sore development.<br><br>An undated facility policy titled: Skin Care Procedure, indicated staff would complete a Braden Scale assessment upon admission and weekly for the next 3 weeks. The policy revealed staff would complete skin documentation on new admissions with markings on the body figure where skin issues are present. Thereafter, | F 686 | | |

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| F 686 | Continued From page 21 the documentation would be on the weekly body assessment form.<br><br>The policy revealed staff would complete a skin assessment at the time of admission or within 2 hours of admission and daily for the next 7 days. The policy stated staff would complete a skin assessment on readmission within 4 hours of return and if staff identified red areas then they would complete body assessments daily for 7 days.<br><br>On 3/12/20 at 1:20 PM the DON (Director of Nursing) stated the facility used two forms to monitor skin conditions: Skin Condition Report and Pressure Ulcer Documentation. She stated once staff identified a pressure area they document and monitor it on the Pressure Ulcer Documentation form and clearly enter the location and condition of the ulcer. | F 686 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to adequately supervise a resident at high risk for elopement. The resident exited the facility without staff knowledge, which resulted in an immediate | F 689 | | |

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| F 689 | Continued From page 22<br>jeopardy to the health and safety for 1 of 4 at risk residents reviewed (Resident #8). The facility reported a census of 39 residents.<br><br>Findings included:<br><br>A Minimum Data Set (MDS), dated 12/5/19, revealed Resident #8 admitted to the facility on 2/27/19. The MDS identified Resident #8 as independent with transfers and ambulation. The resident did not use an assistive device (walker or cane) to ambulate. Resident #8 had diagnoses that included: Parkinson's disease and dementia. The resident scored 9 out of 15 on the Brief Interview for Mental Status (BIMS) test indicating moderate cognitive impairment. The MDS identified the resident with disorganized thinking and in-attention behaviors on a continuous daily basis. The MDS identified the behavior of pacing daily and wandering that placed the resident at significant risk of getting to a potentially dangerous place (outside). The wandering also intruded on the privacy of others. The MDS identified the wandering behavior as "worse" since the previous assessment. A balance during transitions and walking test revealed the resident as not steady but able to stabilize without staff assistance in all areas of testing other than moving on/off the toilet. The resident had 2 or more falls without injury since the prior assessment. The MDS also revealed Resident #8 wore a wander-guard/elopement device on a daily basis.<br><br>Resident #8's care plan with problem start date of 3/6/19 identified the resident at risk for falls due to poor technique while ambulating and dementia. The "approach" section of the care plan revealed the resident wandered as a part of his dementia. | F 689 | F 689<br><br>Thomas Rest Haven ensures alarm and elopement training for all employees and agency personnel. As of 3/17/2020 the facility has in place a formal training video and written formal training method of alarms to be used during orientations of new employees and at employee training in-services. In-service for staff was completed on 12/23/2019 and an alarm re-education was completed on 3/17/2020 prior to surveyors exiting. DON and Administrator will investigate and report any elopements in a timely manner to the Department of Inspections and Appeals. Administrator/DON and/or designee will monitor HR for compliance on a monthly basis for the next 3 months to ensure both new employees and agency/pool employees are trained prior to working. Any concerns will be discussed and monitored by the QAPI Committee. | 3/19/20 |

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| F 689 | Continued From page 23<br>The care plan directed staff to keep the resident in a safe environment and the resident wore a wanderguard. The care plan also directed staff to intervene if the resident walks too fast. The care plan also revealed the resident may need a different level of care due to his dementia and instructed staff to explore alternative care options with family. Discuss benefits/option to placement settings, arrange for discharge planning conference when assessment by the care plan team recommended a different level of care and complete an elopement assessment quarterly and as needed. Care plan also stated to continue with wander-guard. There were no revisions in the care plan based on the MDS identifying the resident's wandering behavior as "worse".<br><br>An elopement risk assessment, dated 12/5/10 identified the resident with a score of "6" (high risk).<br><br>Observation showed on 3/9/20 at 11:30 AM the resident walk across the living room area very quickly to the front door in an attempt to follow a visitor out. The surveyor then attempted to leave the facility for lunch. Staff at the desk next to the door stopped the resident at the front door and asked the surveyor to wait for a minute so they could get the resident back to the living room area. The resident stood at the desk area holding on to the desk and a CNA (certified nurse aide) walked the resident to a chair into the living room area.<br><br>Resident progress notes:<br><br>11/1/19 at 4:33 p.m., revealed the resident continued to roam throughout facility during the shift and made several unsuccessful attempts to | F 689 | | |

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exit out of doors.

11/9/19 at 4:57 p.m., revealed the resident roamed the hallways per normal for the resident. The resident exit seeking and unsuccessful at exiting the building.

12/10/19 at 5:39 p.m., revealed the resident wandered throughout the facility until mealtime. The resident did not exit seek but continued to go into other resident's rooms, nurses office, and tried to get into the nursing med carts.

12/12/19 at 5:01 p.m., revealed the resident wandered the halls and peeked into other resident rooms. The resident attempted to exit via the front door without success.

12/19/19 at 10:00 p.m., revealed the resident wandered through the halls as usual. Staff could easily redirect the resident.

12/21/19 at 9:57 p.m., revealed the resident wandered and attempted to exit without success.

12/22/19 at 5:48 p.m., revealed the resident wandered and attempted to exit seek without success.

An accident/Incident report dated 12/22/19 at 6:45 p.m. completed by Staff Q revealed Staff I (off duty registered nurse) observed the resident in the facility parking lot by the dumpsters while in her car leaving the facility. Staff I pulled back in and got out of her car and brought the resident back into the building. Wanderguard alarm sounding.

Review of Resident #8's medical record showed

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Continued From page 25 nothing documented regarding the elopement. Resident progress notes did not contain an entry regarding the incident and the record failed to identify staff assessed the resident for injuries or that staff notified the resident's physician or family member.

On 3/11/2020 at 9:54 a.m., Staff I Registered Nurse (RN) reported she completed her 6 a.m. to 6 p.m. shift on 12/22/19 and punched out at 6:45 p.m. to go home. She left through the north door and walked across the parking lot to her car. Staff I stated she sat in her car for just a few minutes to make a quick phone call and then started to back her vehicle out of her parking space. Staff I stated as she backed out of the parking space, she happened to look up and see Resident #8 standing in the parking lot near the dumpsters. Staff I stated she immediately pulled her car back into her parking space, got out of her car and walked over to the resident. Staff I took his hand and walked him back into the building. She stated the alarm sounded at the north exit door and she silenced the alarm once inside. Staff I stated she heard the wander guard alarm sounding on the north door prior to reentering the facility with the resident. Staff I also stated no on-duty staff responded to the alarm that sounded on the north door. Staff I stated she went to the north door herself to silence the wander guard alarm and identified the north door area as the only place staff can silence the alarm. Staff I stated she completed a written statement regarding the incident and placed it under the DON's door on 12/23/19. She never heard anything more about the incident or written statement. Staff I stated she did not document the incident in the record because she was off-duty when it occurred. Staff I commented it

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Continued From page 26 was a good thing she happened to be in the parking lot at the time. She stated the resident moves fast and would have been "long gone" had she not been there. Staff I estimated the resident outside 5 to 7 minutes at the most. On 3/30/2020 at 9:38 a.m. Staff I stated the resident wore a long sleeved shirt, jeans and shoes and socks when she observed him outside. The resident didn't say anything about feeling cold. Staff I stated a normal person would have felt cold if they were outside wearing only what the resident wore.

On 3/11/20 at 1:00 p.m., the Director of Nursing (DON) revealed that she did not receive Staff I's statement about what occurred on 12/22/20. The DON stated she became DON on 12/12/20 but still shared the office with the previous DON. The previous DON possibly received Staff I's statement. The DON stated she received a call at home from Staff I and then she phoned the Administrator and the previous DON to report staff observed Resident #8 in the parking lot behind the building around 6:45 p.m. in the evening. The DON provided copies of staff statements she received on 3/11/20 (during the survey) regarding Resident # 8 leaving the building unattended on 12/22/19.

On 3/11/20 1:24 PM Staff M CNA (certified nurse aide) stated she was in the dining room when she heard the wander guard door alarm go off. She walked to the south door to check it but no alarm sounded at that door. She announced on the walkie that the south door (front door) to the facility was clear and walked to the nurse station area to try to assist the other staff with figuring out how to silence the alarm since they stood looking at the panel. Shortly after this, Staff I

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Continued From page 27 returned into the building with the resident and said the resident was outside. Staff I told us how we needed to check and make sure where the residents were.

Staff M's CNA statement revealed she worked the evening of 12/22/20 when Resident #8 left the building. Staff M identified self as in the dining room assisting a resident when she heard an alarm sound. Staff M stated she went to the living room door (South door) and then went to the north door and announced on the walkie-talkie to all staff that the doors were clear. Staff M then went back to the alarms panel and Staff I informed her Resident #8 got out of the facility unattended.

Staff R's Licensed Practical Nurse (LPN) statement dated 3/11/20, revealed she worked on 12/22/20 and clocked out and left the facility at 6:15 p.m. Staff R was not present when Resident #8 had left the building unattended.

On 3/11/20 at 2:08 p.m., Staff Q LPN (agency nurse) stated she worked the evening of 12/22/19 when the resident left the facility. Staff Q stated she responded to the alarm by walking to the alarm panel at the nurse's station. She looked at the panel and did not see any door alarm lights on. Staff Q stated she and Staff N Certified Medication Aide (CMA) stood at the alarm panel at the nurse's station looking for door lights on the panel. A few minutes later, Staff I RN walked into the facility through the north doorway with Resident #8 walking with her. Staff Q stated she did not know what the alarm sound meant and, prior to working at the facility, she did not receive any training at the facility on what different types of alarms they used at the facility. Staff Q stated

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Staff I RN went to the north door at the service entrance and silenced the wander guard alarm. Staff Q stated she called the DON (current DON) at home and updated her on the incident regarding Resident # 8 getting out of the building and observed in the parking lot by Staff I. Staff Q stated that the CNAs working at the facility that evening did not respond to the alarm and did not check the doors either.

On 3/11/20 at 6:23 p.m., Staff L CNA revealed she arrived to work at the facility on 12/22/20 at 6:00 p.m. Staff L stated when she heard the alarms sounding, she went from door to door to try to determine what door alarm activated. Staff L stated when she walked towards the center area by the nurse's station, she saw 2 staff coming back into the building from the north door with Resident #8 walking with them. Staff L stated she did not know if the alarm that activated was a regular door alarm or if it was a wander-guard alarm. Staff L stated she did not receive training to know the difference between the different door alarm sounds at the facility.

On 3/12/20 at 10:32 a.m., Staff N CMA (certified medication aide) revealed she worked at the facility on 12/22/19 at 6:45 p.m. when Resident #8 eloped. Staff N stated she just started her shift at 6:30 p.m. and received report and proceeded to conduct narcotic count, when an alarm went off. Staff N stated the alarm was a very loud constant buzzing noise and when she looked at the alarm panel at the nurse's station with Staff Q, they could not determine what door was alarming since the panel did not contain any lights lit up. Staff N stated she just completed her training at the facility and identified the night of the elopement as the first night she worked on

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Continued From page 29 her own. She stated she did not receive training to know the difference between the different door alarms the facility had. She stated that while she stood at the panel with Staff Q, Staff I came into the building through the north doorway with Resident #8 walking with her. Staff I stated she assumed Resident #8 followed Staff I out the north door and that Staff I then brought the resident back into the building.

On 3/12/20 at 10:52 a.m., the State of Iowa Climatologist identified the weather conditions in Coon Rapids on 12/22/20 at approximately 6:45 p.m. He identified the temperature as 43 degrees with a wind chill of 35 degrees. The winds were from the SSW at 17 miles per hour. There were low clouds and zero precipitation and visibility was 10 miles.

On 3/12/20 at 6:07 p.m. Staff K CNA stated she worked the evening of 12/22/19 when the resident eloped. Staff K stated she heard an alarm sound as she assisted a resident in bathroom. Staff K stated she could not leave that resident, so she could not respond to the alarm right away. Staff K stated after she finished assisting the resident out of the bathroom, she responded to the nurse's station where the alarm sound came from. When Staff K arrived at the nurse's station, she stated all of the staff on duty stood around talking about Resident #8 getting out of the building and Staff I bringing him back into the building.

Observation of elopement area :
Starting at the alarm panel where Staff Q stood looking at the alarm panel, immediately to the right of the panel was a short hallway approximately 20 feet long containing 2 doorways

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Continued From page 30 on the right side. The short hallway contained a doorway (2nd door on the right), which was just a regular door without any type of an alarm on it. After getting through that door, there was a short hallway approximately 15 feet in length. At the end of that hallway, was the north exit that led outside, from which the resident eloped. This doorway contained the wander-guard alarm key pad. (The keypad to the right) and the regular door alarm is located on the left with keypad for the regular door alarm. Once out the north door is the parking lot area that contains a partially covered, awning like area where the food deliveries, ambulance etc. do pick-ups and deliveries for goods and services and for residents at the facility. Several staff referred to this area as "the service entrance area". This area is all concrete and level. Continuing to walk north towards the garage/shed area
(approximately 150 feet), is where there are 3 large dumpsters and where the off duty staff member observed the resident on the night of 12/22/20. The entire parking lot is a paved concrete area. Behind the garage area is the street where the staff member was parked when she saw the resident standing by the dumpsters. To the immediate left of the awning area is a driveway that connects the parking lot and then 100 feet to the side street. The facility generator is also located to the left side next to the driveway area. The posted speed limit is 25 mph. The facility is surrounded on 3 sides by streets and sits on 1 city block. The other ½ of the building is the attached clinic and the assisted living.

An undated facility policy titled Elopement Policy revealed the facility strived to prevent elopement of resident's from the facility. The policy defined elopement as when a resident exits the facility

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undetected and assessed as unsafe to leave the facility unattended. Steps included:

a. The facility would assess all residents for elopement risk upon admission and quarterly thereafter to determine if they are at risk for elopement.
b. The facility would place a wander-guard bracelet (a signaling device that a resident has left the building) on residents determined at risk for elopement.
c. Charge nurses are responsible to see that the wander-guard is placed on the resident initially and will document each shift that the bracelet is in place.
d. The maintenance department checks and documents daily that all facility door alarms, wander-guard door alarms, and bracelet function of residents function correctly. They will report any malfunctions of these systems to the Administrator and the Director of Nursing (DON).
e. Signs are posted at each exit to remind families/visitors to not let any residents exit the building without the assistance of a staff member.
f. The facility will notify all families on admission and at least yearly to not assist any resident to leave the facility.
g. When a door alarm sounds, staff members will immediately check the exit indicated by the indicator lights at the nurse's station.
h. Staff will redirect any resident attempting to leave the building if possible and to return to the facility.
i. If it is determined that a resident is missing, staff shall follow the missing resident procedure. j. Any resident who elopes will have their care plan re-evaluated by the DON or care plan team members.
k. The Quality Improvement Committee will

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| F 689 | Continued From page 32 evaluate all elopement investigations and reports for the circumstances surrounding the elopement and for possible changes needed in facility systems and procedures.<br><br>During an interview with the Administrator on 3/18/20 at 9:50 a.m., he reported he discussed the elopement with the former DON and she informed him Resident #8 exited the facility and Staff I accompanied the resident throughout the entire incident.<br><br>Abatement:<br><br>The facility abated the immediate jeopardy on 3/17/2020 following completion of an agency employee orientation checklist and training video and education of all staff regarding the alarms in use at the facility and procedure for responding to alarms. Surveyors verified corrections were in place prior to exit. | F 689 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that--- | F 758 | | |

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§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 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 record review and staff interview, the facility failed to complete adequate Gradual Dose Reduction (GDR) reviews on psychotropic medications. The facility also failed to limit the timeframe for as needed (PRN) antianxiety

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| F 758 | Continued From page 34 medication to 14 days, unless the physician deemed a longer time frame was appropriate for 2 of 6 residents reviewed for unnecessary psychotropic medications. (Resident #33 and Resident #38). The facility reported a census of 39 residents.<br><br>Findings include:<br><br>1. A Minimum Data Set (MDS) with reference date of 2/5/20, revealed Resident #33 with diagnoses that included: Alzheimer's dementia, anemia, and depression. The MDS documented the resident required extensive assistance of two for bed mobility, dressing, toileting, transfers, and hygiene. The resident had a Brief Interview for Mental Status (BIMS) score of "8" which identified moderate cognitive impairment.<br><br>Resident #33's current care plan updated 1/23/20, did not contain information regarding the use Sertraline (antidepressant) and Lorazepam (antianxiety) on a routine basis or potential side effects.<br><br>Resident #33's March 2020 medication administration record (MAR) revealed an order for Sertraline 100 milligrams (mg) daily initiated 2/6/19. The resident also received Lorazepam 0.5 mg once per day on Wednesday's and Saturdays initiated 2/6/19.<br><br>A Gradual Drug Reduction (GDR) form dated 6/11/19 for Sertraline 50 mg daily. The mental health provider increased the medication to 100 mg. daily and did not write specific clinical rationale why the medication needed to be increased. A second GDR form dated 11/12/19 from the mental health provider stated no | F 758 | F 758<br><br>Thomas Rest Haven ensures each residents drug regimen is managed and monitored to promote and maintain the residents highest practicable mental, physical, and psychosocial well-being. Resident #38 is no longer a resident at the facility. Resident #33 drug regimen has been addressed by the resident's physician. New Pharmacy Consultant will review all resident's medication records monthly and provide detailed GDR requests, as warranted. Staff were educated on GDR's (including PRN Psychotropic medications) and physician documentation on 3/31/2020. DON or designee will ensure GDR's are addressed timely by physician to include clinical rationales as appropriate. DON or designee will continue to monitor for compliance on a monthly basis for the next 3 months. Concerns will be discussed and monitored by the QAPI Committee. | 4/10/20 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THOMAS REST HAVEN | 217 MAIN STREET COON RAPIDS, IA 50058 |

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| F 758 | Continued From page 35<br>change, continued anxiety. A GDR for Lorazepam dated 11/12/19 stated no change and to continue medication as resident was combative with staff. This was the only GDR found in the record and within the first year of the medication's start date of 2-6-19. There was no record of a second GDR ever being completed.<br><br>On 3/17/20 at 5:56 p.m. the Director of Nursing (DON) revealed she knew of the GDR requirements for the continued use of Resident #33's Sertraline and Lorazepam. The DON stated the mental health provider should include rationale regarding why or why not the medications required adjustment. The DON stated she would work with the provider to get the proper GDR documentation needed for the psychotropic medications used at the facility.<br><br>Review of the facility's undated Psychotropic Medication Policy and Procedure included the following information:<br><br>Policy- Physicians and mid-level providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. Primary care physicians, PA (Physician's Assistants) and APN (Advanced Practice Nurses), should attempt a GDR decrease or discontinuation of psychotropic medication after no more than 3 months unless clinically contraindicated. Gradual dose reduction must be attempted for 2 separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants.<br><br>2. A MDS with reference date of 2/17/20, | F 758 | | |

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| F 758 | | F 758 | | |

Continued From page 36 revealed Resident #38 had diagnoses that included: anemia, congestive heart failure, chronic kidney disease, depression and anxiety disorder. The MDS documented the resident was independent with bed mobility, transfers, and eating and required limited assist of 1 staff with dressing, toileting and personal hygiene. The resident had BIMS score of 15 (no cognitive impairment).

Resident #38's current care plan updated 2/25/20, identified the resident with difficulty adjusting to the nursing home from previous living arrangements. The care plan directed staff to monitor the resident for side effects or changes in mood related to antidepressant and antianxiety use. (increase weight, increased appetite, drowsiness/fatigue, insomnia, dry mouth, blurred vision and constipation).

Resident #38's active physician's orders in the electronic health record revealed she was prescribed Diazepam 5 mg 1 tablet by mouth, three times per day as needed for anxiety initiated 2/10/20 with no stop date listed or review of the medication after the initial 14 days.

Resident #38's February 2020 MAR revealed the resident used the as needed (PRN) Diazepam order on February 24th, 25th, 26th, 27th (2 doses) and 28th. The PRN Diazepam medication was given a total of 6 times beyond the 14 day requirement for use of this type of medication.

Resident #38's March 2020 MAR revealed the resident used the PRN Diazepam order on March 1st (2 doses), 2nd, 3rd, 4th (2 doses), 5th , 6th, 7th, 8th (2 doses). Staff administered the PRN

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| F 758 | Continued From page 37<br>Diazepam 11 times in March beyond the 14 day requirement for use of this type of medication.<br><br>O 3/17/20 at 5:32 p.m. the DON revealed she knew of the 14 day requirement to limit the duration for initial use of Resident #38's PRN Diazepam. The DON acknowledged the resident received 17 doses of the PRN Diazepam beyond the 14 days. The DON stated she planned to work with the resident's primary care physician and the facility's mental health provider to assure psychotropic medications are ordered and reviewed appropriately and within the 1st 14 days of the start of any PRN anti-anxiety medication.<br><br>Review of the facility's undated Psychotropic Medication Policy and Procedure included the following information:<br>Physicians and mid-level providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring.<br>Primary care physicians, PA and APN will order PRN psychotropic medications to be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances. | F 758 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview, the facility failed to ensure that it was | F 759 | | |

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| F 759 | Continued From page 38 free of medication error rates of five percent or greater. Twenty-six medications were observed with 2 errors resulting in a 7.6% medication error rate. (Residents #9, Resident #142) The facility reported a census was 39 residents.<br><br>Findings Include:<br><br>1. According to the electronic chart, Resident #9 was admitted to the facility on 9/10/13 with diagnosis that included hemiplegia, heart failure, prosthetic heart valve, chronic obstructive pulmonary disease (COPD) and diabetes mellitus. The care plan dated 3/1/20, revealed the resident required assistance with activities of daily living (ADLs). The resident had difficulty communicating due to stroke and had complications related to diabetes mellitus.<br><br>A Minimum Data Set (MDS) dated 2/28/20, assessed Resident #9 with a Brief Interview Mental Status (BIMS) score of 10. A score of "10" identified moderate cognitive impairment. The resident required extensive assistance with the help of one for bed mobility, transfers and toileting. According to the electronic record, Resident #9 had a physician's order, dated 10/8/19, for Lantus 100 units/milliliter (ml.)71 units to be given subcutaneously in the morning.<br><br>Observation showed on 3/10/20, Staff J LPN (licensed practical nurse) prepare morning medications. At 6:09 AM, she gathered the supplies and Lantus insulin pen for Resident #9. Staff J dialed up the Lantus pen to 71 units without having primed the needle to ensure the pen contained the proper number of units. She then administered the insulin to the resident. | F 759 | F 759<br><br>Thomas Rest Haven does provide cares and services according to accepted standards of clinical practice. Resident #9 and #142 and all like residents with insulin orders will have insulin pens primed prior to administering medication. Nursing staff were educated on 3/10/2020 re: proper technique of administering insulin via insulin pens. DON and/or designee will continue to monitor for compliance on a random 1-time week basis for 4 weeks. Concerns will be discussed and monitored by the QAPI Committee. | 4/10/20 |

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| F 759 | | F 759 | | |

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2. A MDS for Resident #142 dated 2/5/20, revealed a BIMS score of 15 (no cognitive impairment). The resident required limited assistance with the help of one for bed mobility and toileting and required extensive assistance with the help of two with transfers and dressing. The baseline care plan dated 3/6/20 following readmission to the facility after a hospitalization identified the resident required assistance of 2 for bed mobility, transferring and toileting.

According to the physician's order set dated 3/6/20, Resident #142 had diagnosis that included: cellulitis of the lower limbs, pressure ulcer of the sacral region, acute respiratory failure and diabetes mellitus.

Physicians orders dated 3/6/20 directed staff to administer Lantus U-100 insulin pen 100 unit/ml. Administer 10 units subcutaneously twice a day.

On 3/10/20 at 6:26 AM Staff J LPN retrieved the insulin pen for Resident #142 and dialed it to 10 units without having primed the needle first. She then administered the medication to the resident.

On 3/18/20 at 9 AM the Director of Nursing (DON) on 3/18/20 at 9:00 AM stated she expected the nurses to follow the recommendations of the manufacturer when administering insulin to residents.

In an undated document from the web site: www.lantussolostar.com, the manufacturer directed staff to always do a safety test before injection. 1. Dial a test dose of 2 units. 2. Hold the pen with the needle pointing up. Then gently tap the reservoir so bubbles rise up to the needle. 3. Press the injection button all the way in and check

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| F 759 | Continued From page 40 to see that insulin comes out of the needle. 4. If no insulin comes out repeat the test 2 more times. 5. If there is still no insulin coming out, use a new needle and do the safety test again. | F 759 | | |
| F 773 SS=D | Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii)<br><br>§483.50(a)(2) The facility must-<br>(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.<br>(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to obtain and maintain adequate laboratory (lab) records for 2 of 16 residents. (Resident #22 Resident #39). The facility reported a census of 39 residents.<br><br>Findings include:<br><br>1. A Minimum Data Set (MDS) dated 1/27/20, revealed Resident #22 admitted to the facility on 10/28/19. The resident had a Brief Interview for Mental Status (BIMS) score of "11". A score of 11 identified moderate cognitive impairment. The MDS identified the resident as independent with bed mobility, transfers, and toileting. The resident received an anticoagulant medication daily for | F 773 | | |

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| F 773 | Continued From page 41 each of the 7 days leading up to the 1/27/20 date. The resident had diagnoses that included: atrial fibrillation (abnormal heart rhythm), coronary artery disease, and high blood pressure.<br><br>Resident # 22's care plan with a review date of 2/29/20 revealed a goal that the resident would receive the anticoagulant without serious complications. The care plan directed staff to be aware of the risk for bleeding, report adverse side effects, observe resident for active signs of bleeding such as bleeding from gums, nosebleeds excessive bruising. Staff should monitor lab work as ordered and notify the doctor of results and adjust medication dosage when ordered.<br><br>Resident #22's March 2020 Medication Administration Record (MAR) revealed the resident received Coumadin (a blood thinner) 2 milligrams (mg.) daily.<br><br>Review of Resident #22's International Normalized Ratio (INR) (INR checks how thin the blood is) flowsheet on 3/10/20 at 1:49 p.m. revealed since the resident's admission to the facility on 10/28/19, the facility recorded 4 INRs completed:<br>- 11/25/19 INR 3.3 (high), Coumadin decreased by physician from<br>3 mg daily to 1.5 mg. daily and orders to recheck in 1 week.<br>-12/3/19. INR 1.3 (normal), no change in Coumadin dose and orders to recheck INR on 12/23/20.<br>-12/31/19 INR level is blank and dated 1 week later than 12/23/20. Coumadin orders changed to 1.5 mg every other day alternating with 2 mg tablet every other day. Orders to recheck INR | F 773 | F 773<br><br>Thomas Rest Haven does obtain and maintain adequate laboratory records. Resident #22, #39 and all like residents have had lab orders reviewed and scheduled to be drawn as ordered. Staff were educated on 3/31/2020 to ensure the scheduled labs are drawn timely and lab reports are received, documented, reported to physician as appropriate and filed in charts to ensure timely response of lab results and ensure timely filing of lab records. DON or designee will continue to monitor for compliance on a random weekly basis for 3 months. Concerns will be discussed and monitored by the QAPI Committee. New policy written and put into effect on 4/6/2020. | 4/10/20 |

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| F 773 | Continued From page 42<br>1/13/20<br>-1/30/20 INR 1.4 (normal), Coumadin changed to 1.5 mg daily. No entry for 1/13/20 to indicate INR completed and next INR was not done until 1/30/20.<br><br>Resident # 22's record revealed the following regarding INR checks completed since admission to the facility on 10/28/19.<br>a.) 1st INR check since admission done 11/4/19 with no copy available in the record. Orders received to change Coumadin to 3 mg daily and recheck INR in 1 week.<br>b.) Next INR check done on 11/25/19 with no copy available in the record. Orders to decrease Coumadin to 1.5 mg daily and to recheck in 1 week.<br>c) INR check 1/14/20 not available in the record<br>d.) INR check done on 1/30/20 with 1.4 results. Lab results not available in the record.<br>e.) INR re-checked on 2/7/20 with 1.4 result. Lab results not available in record.<br>f.) INR check done on 2/20/20 with 1.4 result. Lab results not available in the record.<br><br>On 3/16/20 at 9:34 a.m. the MDS Coordinator revealed she completed an audit for the missing lab information/lab slips not available in the chart. The MDS Coordinator stated she would call over to the clinic to find out where the records were.<br><br>On 3/16/20 at 3 p.m. the MDS Coordinator stated the clinic did not regularly send the INR lab sheets to them and the lab faxed over copies to place onto the residents chart for the following dates:<br>- 11/4/19 INR of 1.6<br>- 11/25/19 INR of 3.3<br>- 1/14/19 INR of 1.9 | F 773 | | |

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| F 773 | | F 773 | | |

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- 1/30/20 INR of 1.4 -
2/7/20 INR of 1.4
- 2/20/20 INR of 1.4

On 3/17/20 at 5:27 p.m., the Director of Nursing (DON) stated the MDS coordinator updated her that Resident #22's record did not contain 6 INR lab results. The DON stated the facility will try and improve the communication between the facility and the clinic to assure no more INRS are missed and they have all of the laboratory records in Resident #22's chart. The DON stated she expected all facility nurse's to follow-up appropriately with the clinic to ensure they have copies for the Resident's chart so that any abnormal INR values can be addressed timely. 2. According to the electronic record, Resident #39 admitted to the facility on 1/10/18 with diagnosis that included: dementia, hearing loss, gout and chronic kidney disease. A MDS dated 2/19/20 assessed the resident with a BIMS score of 8 (severe cognitive impairment). The resident required limited assistance of one staff for transfers, dressing and toilet use.

A review of the paper chart revealed a physician's order dated and signed on 12/13/19 ordering laboratory tests that included a Complete Blood Count (CBC), Basic Metabolic Panel (BMP) and Thyroid Stimulating Hormone (TSH) to complete on January 1st 2020 and July 1st 2020. The chart lacked documentation that the facility completed the blood work and did not have copies of the test results available.

On 3/17/20 at 8:18 a.m. Staff S LPN (licensed practical nurse) stated she called the lab and asked them to fax over the results. Staff S stated the clinic indicated the labs were completed

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| F 773 | Continued From page 44<br>1/7/20. On 3/17/20 at 12:36, Staff S received the results of the labs from January 7, 2020. Some of the test that were out of normal range included: Blood Urea Nitrogen (BUN) was high at 20 (normal 7-18). Creatinine was high at 1.59 (normal range .55-1.02). Glomerular Filtration Rate (GFR) was low at 30.6 (normal range 60-128). | F 773 | | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and facility policy review, the facility failed to provide a sanitary dietary environment when dietary staff failed to properly wear a hair restraint and failed to provide appropriate infection control practices during an observation of a noon meal service for | F 812 | | |

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| F 812 | Continued From page 45 residents. The facility reported a census of 39 residents.<br><br>Findings included:<br><br>Observation on 3/9/20 at 11:51 a.m. revealed Staff R Dietary Aide, revealed had full bangs hanging outside of the hairnet staff wore while serving food from the steam table.<br><br>Observation on 3/9/20 at 11:57 a.m., Staff R worked in the kitchen hanging up clean utensils with bangs completely outside of her hairnet.<br><br>Observation on 3/9/20 at 12:16 p.m., Staff R worked in the kitchen with bangs completely outside of hairnet.<br><br>Observation on 3/11/20 at 12:22 p.m. Staff R's bangs hung all the way out on the top of her head and also ¼ of her hair on both sides of the head hung completely outside of her hairnet.<br><br>Observation on 3/11/20 at 12:45 p.m. noted Staff R bagging up garbage in the kitchen with her bangs hanging all the way out on the top of her head and that ¼ of her hair on both sides of the head hung completely outside of her hairnet.<br><br>On 3/12/20 at 11:04 a.m. the Dietary Manager (DM) stated she would need to talk with Staff R about retraining her hair properly. The DM stated she was new to her position and stated Staff R always wore her hairnet that way and since it was her normal appearance, she did not realize it was an issue.<br><br>On 3/12/20 at 12:59 p.m., the DM stated she educated Staff R on the proper way to restrain | F 812 | Thomas Rest Haven will ensure all Dietary employees have been educated on the proper use of a hair net. On 3/19/2020 the Dietary Manager held a training meeting and discussed the proper way to wear a hair net.<br><br>Thomas Rest Haven will ensure all Dietary cooks have been educated on the proper food safety requirements. The Dietary Manager held a training meeting on 3/19/2020 to educated employees on the proper food safety requirements. If any foreign matter comes in contact with any food, that food needs to be removed and other food needs to be made in its place. The Dietary Manager or designee will ensure both hair nets and food safety requirements are being adhered to by making random checks throughout the kitchen. | 4/10/20 |

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| F 812 | | F 812 | | |

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her hair in the hairnet and that she would ensure Staff R continued secure her hair wit the hair net.

Review of the Facility's policy with a revision date of November 14th, 2012 Sanitation and Staff Hygiene stated the following:

Policy- All local, state, and federal standards and regulations are followed in order to assure a safe and sanitary department.
Procedure for Sanitation and Staff Hygiene:
a. The staff will maintain sanitation of the kitchen through compliance with a written cleaning schedule.
b. The staff will follow proper hand washing practices.
c. The staff will document dishwasher temperatures.
d. The staff will have annual reviews of sanitation practices.
e. There will be no fingernail polish or fake nails to be worn in the kitchen.
f. Hairnets will be worn at all times.

2. During a dining room observation on 3/10/20 at 12:03 p.m., observation showed Staff D (cook) serve the noon meal. Midway through the meal service, a dietary card slipped off the top of the steam table and fell into the pan of gravy. The dietary card landed in the gravy and was submerged three-fourths of the way before Staff D reached into the gravy and removed the dietary card. Staff D continued to serve the gravy to the remaining 20 residents left to serve.

On 3/11/20 at 12:37 p.m. the DM stated Staff D informed her of the dietary card falling into the gravy on 3/10/20. The DM stated she instructed Staff D that she should not have served the gravy

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| F 812 | Continued From page 47<br>to the remaining residents.<br><br>On 3/1//20 at 12:44 p.m., Staff D stated she should not have continued to serve the gravy to the residents after the dietary card fell into it. Staff D stated if this ever happened in the future, she would discard the old gravy and just make new to ensure the gravy was not contaminated from a foreign object falling into it. | F 812 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F 880 | | |

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| F 880 | Continued From page 48<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(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:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by: | F 880 | F 880<br><br>Thomas Rest Haven provides a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Resident #19 and other residents receive peri-care from staff using proper handwashing and proper peri-care from staff using proper handwashing and proper peri-care technique. Staff were re-educated on 3/17/2020 regarding proper peri-care and handwashing technique. Resident #19, #33, #38 and all like residents have had their O2 tubing replaced and a system is in place to ensure O2 tubing is changed routinely. Nurses were educated on changing of O2 tubing process on 3/31/2020, 4/1/2020 and 4/6/2020. DON or infection Control nurse will monitor for compliance thru weekly audits of O2 tubing, peri-care and handwashing for 3 months. All resident | 4/10/20 |

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| F 880 | Continued From page 49<br>Based on observation, record review and staff interview, the facility failed to utilize appropriate infection control practices during resident care for 1 of 3 residents reviewed (Resident #19) and failed to maintain cleanliness of oxygen tubing for 3 of 3 residents reviewed for oxygen use (Resident #19, #33, and #38). The facility reported a census of 39 residents.<br><br>Findings included:<br><br>1. A Minimum Data Set (MDS) assessment dated 12/19/19, assessed Resident #19 with a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The resident had diagnoses that included: malignant neoplasm of prostate, pulmonary (lung) hypertension (high pressure) and coronary artery disease. The MDS indicated Resident #19 required extensive assistance of two staff for bed mobility, transfers, and toileting. The resident was always incontinent of bowel and bladder and did not have a toileting plan.<br><br>Resident #19's care plan with a revision date of 3/1/20 revealed the care plan did not contain any information regarding his urinary incontinence, nor any interventions for staff to manage his incontinence.<br><br>Review of Resident #19's Medication Administration Record (MAR) on 3/10/20 at 10:39 a.m. revealed an active medication order dated 3/3/20 for Augmentin 875-125 mg, give 1 tablet by mouth twice per day for 10 days for Urinary Tract Infection (UTI).<br><br>A laboratory specimen report dated 3/2/20 revealed a urine culture and sensitivity report | F 880 | EMARS have been updated to include weekly reminders regarding changing O2 tubing/equipment per policy. Any concerns will be discussed and monitored by the QAPI Committee. | |

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Continued From page 50 showing Resident #19's urinalysis had greater than 100,000 CFU (colony forming units) of the organism Proteus Mirabilis, actively growing in his urine. The organism was susceptible to Augmentin and the Physician gave the order to start the Augmentin 875 mg by mouth twice a day for 10 days.

Observation on 3/10/20 at 1:17 p.m. revealed Staff A Certified Nursing Assistant (CNA) and Staff B CNA performed perineal care for Resident #19. Staff used the EZ stand lift to lower the resident onto the toilet. Staff A removed the resident's brief and reported incontinence of urine. While resident sat on the toilet, Staff A placed a new, clean brief between resident's legs and pulled the side up and around the resident's pants prior to providing incontinence care. Staff B then proceeded to use wipes to cleanse residents groin folds and front perineal area, Staff B failed to turn the cloth with each wipe to assure a clean surface made contact with the skin each time. Staff B did not thoroughly cleanse the penis and groin areas and did not retract the foreskin to cleanse the tip of the penis. Staff B then removed her gloves, and washed her hands. Staff A raised Resident #19 into a standing position with the EZ stand lift. Staff B donned new gloves, cleansed his buttocks and hips regions. Staff A then pulled up the previously placed incontinence brief around resident's pelvic region and fastened the tapes on each side. Staff A then pulled up his pants and with Staff B's assistance, lowered resident back into his wheelchair.

Observation on 3/11/20 at 8:22 a.m. Staff A CNA and Staff C CNA assisted Resident #19 to use the restroom. Staff C washed her hands with

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Continued From page 51 soap and water at the sink and turned off the faucet with a wet paper towel. Staff A did not wash her hands but instead used hand sanitizer and put on clean gloves. Resident #19 transferred the resident from his wheelchair onto the toilet per the use of the EZ stand lift. Staff A removed the old soiled brief and placed a clean, new brief into resident's pants while he sat on the toilet prior to peri-care. Staff A stated resident needed to have a bowel movement (BM) and would need to sit on the toilet for awhile. Staff C noted the battery pack on the EZ stand lift was low and removed the battery pack from the lift and exited the room. Staff C returned several minutes later with a new battery pack and placed the battery pack back into the EZ lift machine. Staff C did not wash her hands or perform hand hygiene before leaving or after returning to the restroom area. Staff A then requested Staff C to apply gloves to help clean Resident #19 up as he finished using the restroom. Staff C applied gloves and handed wet wipes to Staff A. Staff A wiped resident's groin folds, wiping from the groin folds, towards the outer hip area instead of down and away. Staff A repeated this same technique for both sides of the groin fold areas. Staff A used a third wipe to cleanse the tip of the penis and to pull back resident's foreskin to cleanse all soiled areas. Staff A then removed her gloves and washed her hands at the sink. Staff C lifted Resident #19 up into a standing position and cleansed his buttocks with clean wipes using a down and back motion and turning the cloth each time for a clean surface. Staff C removed her gloves and pulled up resident's incontinence brief. Staff lowered the resident into his wheelchair with the EZ stand. Staff A and C then proceeded to the sink and washed their hands with soap and water.

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On 3/11/20 at 2:06 p.m. Staff B stated she did clean the tip of Resident #19's penis with a wet wipe, but agreed it was hard to see due to the placement of the brief into resident's pants. Further discussed with Staff B in regards to not using a clean surface each time she had wiped Resident #19's soiled peri-areas in the front and did not turn the cloth to assure the resident was properly cleaned. Staff B stated she agreed and stated she knew Resident#19 currently had a UTI.

On 3/12/20 at 1:45 p.m. Staff C stated she did not recall shutting the faucet off with the wet paper towel she dried her hands with. Staff C confirmed when she had went to get the new battery pack for the Z stand lift, she did not wash her hands at the sink prior to leaving the restroom and did not wash her hands when she returned. Staff C also confirmed she had not washed her hands prior to placing gloves on to assist Staff A complete the incontinence care for Resident #19. Staff C voiced she was aware that Resident #19 had a current UTI.

On 3/12/20 at 3:04 p.m. the Director of Nursing (DON) confirmed she knew of the handwashing and incontinence care concerns with Resident #19. The DON stated she discussed the concerns with Staff A, B and C. The DON stated she expected staff to follow proper infection control processes with both handwashing and incontinence care.

Review of the facility's undated Hand Hygiene Policy and Procedure, stated all staff on the healthcare team are required to comply with current Centers of Disease Control and

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Prevention (CDC) hand hygiene guidelines. The policy stated in part that handwashing is indicated when:

a. Hands are visibly dirty or contaminated or are visibly soiled with blood or other body fluids, wash hands with either a non-anti-microbial soap and water or an anti-microbial soap and water.
b. Before eating and after using the restroom.
c. To routinely decontaminate hands in the following clinical situations
-before having direct contact with patients
-After contact with body fluids or excretions, mucous membranes, non-intact skin, and wounds dressings, even if hands are not visibly soiled.
-After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
-After removing gloves.

The Policy further included a non-surgical Hand Hygiene technique for handwashing that included the following steps:

a. Wet hands with running water.
b. Apply hand washing agent to hands.
c. Vigorously rub hands together for at least 15 seconds, covering all surfaces of hands and fingers.
d. Rinse hands thoroughly with water and with hands angled down in the sink.
e. Dry hands thoroughly with a disposable towel(s).
f. Use disposable towel to turn off the water.

Oxygen Tubing

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Observation on 3/11/20 at 9:20 a.m. revealed the resident's oxygen tubing did not contain a date on it. The resident sat in his wheelchair receiving oxygen via nasal cannula.

Resident #19's chart revealed the resident's oxygen orders did not include when to change or replace the oxygen tubing.

On 3/17/20 at 9:13 a.m. DON stated the facility did not have a process in place to change oxygen tubing routinely. The DON stated she changed oxygen tubing when she worked the nursing floor but stated there was not a way to know how long the oxygen tubing was in place since it was not dated. The DON further stated she thought the policy was to change the tubing monthly, but she was not sure. She stated the Administrator may have a policy.

The Administrator stated on 3/17/20 at 9:25 a.m., that he could not locate a policy or procedure with directives on how often the oxygen tubing for residents needed changing.

2. A MDS dated 2/5/20, assessed Resident #33 with a BIMS score of 8, indicating moderate cognitive impairment. The resident had diagnoses that included: anemia, Alzheimer's dementia, and Chronic Obstructive Pulmonary Disease (COPD). The MDS identified the resident utilized oxygen and received hospice level of care. The resident required extensive assistance of two staff for bed mobility, transfers, dressing and toileting.

Observation on 3/11/20 at 9:14 a.m. showed Resident #33's oxygen tubing to have no dates written or labeled on it. The resident sat in her

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Continued From page 55 side chair in her room receiving oxygen via nasal cannula.

Resident #33's chart revealed signed physicians orders dated 2/7/20 with an active order for Oxygen at 2 - 5 liters per nasal cannula to keep oxygen levels greater than 90%. The order did not include when to change or replace the oxygen tubing.

On 3/17/20 at 9:13 a.m. DON stated the facility did not have a process in place to change oxygen tubing routinely. The DON stated she changed oxygen tubing when she worked the nursing floor but stated there was not a way to know how long the oxygen tubing was in place since it was not dated. The DON further stated she thought the policy was to change the tubing monthly, but she was not sure. She stated the Administrator may have a policy.

The Administrator stated on 3/17/20 at 9:25 a.m., that he could not locate a policy or procedure with directives on how often the oxygen tubing for residents needed changing.

3. According to the electronic record, Resident #38 readmitted to the facility on 3/6/20 after a hospitalization for a pulmonary embolism and syncope episodes. According to a physician's order dated 3/6/20 the resident had diagnosis that included: cellulitis of the lower limbs, pressure ulcer of the sacral region, acute respiratory failure and type 2 diabetes mellitus.

A MDS dated 2/5/20 assessed the resident with a BIMS score of 15 out of 15, indicating no cognitive impairment. The resident required limited assistance of 1 staff with bed mobility and toilet use. He required extensive assistance of 2

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Continued From page 56 staff with transfers and dressing. The baseline and readmission care plan dated 3/6/20 revealed the resident required assist of 2 and totally dependent for bed mobility, transfers and toileting.

Observation showed on 3/10/20 at 9:20 AM Staff O CNA transferred off of the commode and into the recliner. The resident wore a nasal cannula with the oxygen concentrator set at 4 liters. The oxygen tubing lacked any markings of when it was last changed. The night stand contained unused oxygen tubing.

4. A review of the medical record revealed that Resident #7 admitted to the facility on 4/18/20 with diagnosis that included: dementia, type 2 diabetes mellitus, bipolar disorder and heart disease. A BIMS test assessed the resident with a score of 6, severe cognitive impairment. The electronic record identified the resident with an order dated 9/4/19 for continuous oxygen at 2 liters per nasal cannula.

Observation showed on 3/12/20 at 1:38 PM the resident asleep in a chair in her room with the oxygen nasal cannula attached. The tubing attached to the oxygen concentrator did not have a date documented as to when staff changed the tubing. The electronic chart lacked information regarding the last time the tubing had been changed.

On 3/11/20 at 11:22 AM Staff H RN stated she changes the oxygen tubing when she works but she does not document it anywhere and said she did not know of any standard orders for tubing changes.

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| THOMAS REST HAVEN | 217 MAIN STREET COON RAPIDS, IA 50058 |

| (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 |
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| F 880 | Continued From page 57<br>On 3/10/20 at 7:40 AM Staff R RN stated she did not know when the tubing was last changed and she did not know what the procedure was at the facility for documenting or monitoring that. She stated she had only been with the facility for about a month and "I think they do it on the night shift".<br><br>On 3/12/20 at 1:14 PM the DON stated she changes the oxygen tubing whenever she works but she acknowledged that they do not have a system in place for determining when staff previously changed tubing. She stated there is a notice posted in the breakroom directing staff to change it out monthly.<br><br>In a document from Jackson Medical Supply dated 3/25/19 it stated that "our technicians will change out cannulas every other week and the supply tubing will be changed out once a month" At the bottom of the document the names of the 2 technicians.<br><br>A policy from Thomas Rest Haven revised on 3/17/20 included information that stated staff would change oxygen tubing, nasal cannula/mask weekly. | F 880 | | |