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	165149	A. BUILDING _____ B. WING _____	C 07/02/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 8/2/20 An investigation of Complaints #90926-C , #91635-C, #91673-C , and Facility Reported Incident #90479-I, completed 7/2/20 resulted in the following deficiencies. Facility Reported Incident #90479-I was substantiated Complaint #90926-C was not substantiated Complaint #91635-C was substantiated Complaint #91673-C was substantiated See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda A Barrow RN LNHA — TITLE — (X6) DATE: 7-31-20

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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access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interviews, the facility failed to provide the resident with dignity and respect for 1 of 7 residents reviewed (Resident #1). The facility reported a census of 29 residents.

Findings include:

Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a diagnosis of Amyotrophic Lateral Sclerosis (ALS), chronic

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F 550	Continued From page 2 respiratory failure, unspecified whether with hypoxia or hypercapnia and other dysphagia. On 6/30/20 at 12:58 PM, the resident reported staff talks about her and hospice gossip. There was one staff member that was not nice to her. The resident said the aide did not change the resident, was not kind to the resident, and was the worst aide. The staff want the resident to move faster than the resident could move. Hospice Progress Note dated 3/26/20 at 10:52 PM stated the resident was upset over several things and utilized a communication board and pictures to indicate the resident felt rushed with cares and no one took the time to take things at a pace that did not cause the resident pain. The resident thought no one understood the resident's disease and treated the resident as an invalid. The care plan dated 3/18/20 informed staff to respect the resident's right to make decisions. On 7/2/20 at 8:45 AM, the Director of Nursing (DON) said the resident reported the staff on day shift not as attentive as the night shift. The DON said on 6/15/20, she educated the staff to make them more aware that the staff needed to assist the resident. The DON stated the resident got upset with staff because the resident felt the staff moved too fast for her. The resident would make a comment that the resident "wasn't stupid".	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and	F 558		

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preferences except when to do so would endanger the health or safety of the resident or other residents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to provide reasonable accommodations to meet the residents' needs to communicate efficiently for one of seven residents reviewed. Resident #1 did not have a call light she could effectively use. The facility reported a census of 29 residents.

Findings include:

Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a diagnosis of Amyotrophic Lateral Sclerosis (ALS), chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other dysphagia.

Interviews:

On 6/29/20 at 11:15 AM, Hospice Staff #1, Registered Nurse (RN), said the resident experienced difficulty speaking and could not move her hand easily. Hospice Staff #1 said the resident had good days and bad days. The bad days started in the last two weeks. The resident has communicated with the staff but had three days where the resident couldn't communicate with the staff.

On 6/30/20 at 12:58 PM, Hospice Staff #2, Certified Nurse Aide (CNA), assisted the resident communicate during the interview using a

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communication board. Hospice Staff #2 held the resident's hand up above the communication board to prevent the plastic sleeve from sliding. The resident said within the last two weeks, talking is harder to do. The resident reported on the day of the interview communicating seemed more difficult than the day before. Hospice Staff #1 said the prior Hospice Nurse attempted to visit with the facility about a pressure call light. Hospice Staff #1 stated the DON reported that it was not something the facility could do. The resident spelled out that she felt afraid not to have a call light.

Observations:

On 6/29/20 at 12:44 PM, observation showed Staff I, Licensed Practical Nurse (LPN), attempt to make the resident comfortable. The resident could not communicate concerns verbally and frequently moaned and tried to indicate something was wrong. Staff I used the communication board in a clear plastic sleeve. The resident attempted to spell out words with difficulty. As the resident tried to spell words, the plastic sleeve slid, causing challenges with spelling words. The increased problems caused increased frustration with the resident as the resident wasn't able to communicate the problem efficiently.

Record Review:

A care plan problem dated 3/15/20 identified the resident with a communication problem due to language barrier. The intervention initiated on 4/3/20 included the resident had a communication paper that the resident could spell out words to tell the resident's wants. An intervention dated

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3/15/20 directed staff to monitor and or document the resident's frustration level and wait 30 seconds before providing the resident with a word.

A Health Status Note 5/28/20 at 10:35 AM showed the resident's hands contracted, and the skin on the palms starting to peel slightly. Staff cleaned the resident's hands cleaned thoroughly, and applied lotion.

A Physician Visit Note dated 6/9/20 revealed the resident could communicate with letters on a communication board. The resident could no longer communicate with the phone or with language. The resident could no longer communicate verbally. The resident required support of the left hand to point out letters to communicate. The resident's left wrist contained contractures and caused pain when the resident attempted to straighten it. The note identified the Physician with difficulty communicating with the resident.

On 6/17/20 at 12:37, the Nurses Note revealed the Interdisciplinary Team (IDT) met to discuss the resident's pain. The resident continued with hospice and received an increase of hydromorphone (narcotic). The resident's ability to communicate deceased as well as the patience to do things.

On 6/29/20 at 11:01 AM, the Nurses Note identified the Physician visit/recertification noted the resident remained on an intermediate level of care (ICF) with hospice. The resident showed a progressive decline. Unfortunately, the resident could not communicate her needs adequately. The facility would continue to focus on comfort

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measures.

On 6/29/20 at 17:06, an Activity Participation Note revealed the Activity staff spent time reading mail to the resident. The resident experienced frustration when staff could not understand what the resident needed. The resident could not use the letter chart to help staff with the resident's concern. The activity staff got a CNA to help the resident.

On 7/1/20 at 4:51 PM, a Social Service Note showed a Digital Audio Monitor purchased on 7-1-20. The intention behind the purchase was to add the digital audio monitor to her room to hear the resident better when the resident needed to reach staff and hopefully decrease anxiety level due to call light concerns.

On 7/1/20 at 4:56 PM, the Social Service Note indicated an updated and laminated communication paper board to enable the resident to handle the board and be easier to clean and sanitize.

Administration Staff Interview:

On 7/1/20 at 1:55 PM, the Director of Nursing (DON) said the facility attempted to get something more manageable for the resident to use as a call light. There was no pressure pad available through the call light system. The resident can use the call light, but cannot use it easily. The resident frequently used the call light but the DON denied concerns that the resident would go without help. The DON said the resident worked with Speech Therapy in the past and hated to use pictures as the resident could spell out the words. The charge nurse called hospice

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F 558	Continued From page 7 one day to discuss the use of a baby monitor. Hospice told the nurse that wasn't something they provided. The DON felt the resident could use a baby monitor that the staff could carry, as the resident could still make noise to alert the staff of the need for help. The DON said the facility did not purchase a baby monitor yet for the resident to try. Policy review: The Resident Call System policy dated 4/1/18 showed that residents unable to use the call system due to decreased physical or mental abilities needed staff to anticipate their needs to the best of abilities.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		

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§483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the resident's representative for one of seven residents reviewed (Resident #4). The facility reported a census of 29 residents.

Findings include:

Resident #4's Minimum Data Set (MDS) completed with an Assessment Reference Date

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(ARD) of 5/14/20 identified the resident with short and long-term memory problems (severe cognitive impairment). The MDS revealed the resident with a significant unplanned weight loss (5 percent (%) in the previous 30 days or 10% over the last six months). The Care Assessment Area (CAA) identified the resident with a poor appetite. Staff encouraged and attempted to help the resident eat. The resident had diagnoses of: Cachexia, Alzheimer's Disease, and metabolic encephalopathy.

Record review:

On 5/6/20 at 3:55 PM, the Interdisciplinary Team (IDT) met to discuss the resident's weight, current weight 82.0 pounds (#), down 3.5# since the 4/29/20 IDT meeting. The IDT team identified the resident of advanced age and advancing dementia and they would contact the family to discuss the end of life options.

On 5/7/20 at 12:00 PM, the Social Service Note showed the Social Services staff spoke to the resident's representative concerning the resident's weight loss and falls. They discussed Hospice as an option and the resident's representative agreed to start Hospice. The facility sent a facsimile (fax) to the resident's primary Physician and asked for an order for a Hospice evaluation (eval).

On 5/7/20 at 4:11 PM, a progress note completed as a late entry showed the facility received a signed order for a Hospice eval and notified the chosen Hospice agency of the order.

The resident's weight on 5/11/20 showed 83 pounds, and on 5/18/20 the resident weighed

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68.5 pounds, indicating a weight loss of 12.5 pounds or a loss of 17.47% in seven days.

The resident's record lacked documentation of notification to the resident's representative related to the weight loss.

On 5/21/20 at 9:55 AM, a Social Service Note showed a care plan invitation sent to the Resident's Representative for a care plan scheduled for 6/10/2020 at 10 AM.

A care plan dated 5/21/20 revealed the goal as: the resident would continue to make decisions related to the care and daily routine with assistance from the staff, family, and or Hospice.

On 5/11/20, the Hospice Note showed the Resident's Representatives weren't close to the resident but did want communication-related to the resident's changes. The Resident's Representatives reported that there wasn't much communication regarding the resident's decline reported from the facility. However, they were happy to have Hospice on board.

Interviews:

On 6/30/20 at 12:34 PM, the Hospice Staff #3 identified the Resident's Representative upset and requested a conference call due the facility not giving consistent communication. The Resident's Representative remained upset throughout the care conference. The Resident's Representative did not say they were happy with the communication from the facility. The Resident's Representative decided that Hospice would be the primary point of contact for communication.

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F 580	Continued From page 11 On 7/2/20 at 8:45 AM, the Director of Nursing (DON) identified the Administrator, the Hospice Nurse, and herself as involved in the conference call regarding the Resident's Representative's. During the meeting, everyone agreed to designate Hospice as the primary contact. The DON reported knowing that the facility's notifications as not the best.	F 580		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to complete a required Significant Change Minimum Data Set (MDS) Assessment for 1 of 1 resident reviewed receiving Hospice Services (Resident #5). The facility reported a census of 29 residents. Findings include: 1. The Minimum Data Set (MDS) dated 5/31/20, indicated diagnosis for Resident #5 included	F 637		

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F 637	Continued From page 12 Alzheimer's, chronic obstructive pulmonary disease, and atrial fibrillation. According to the MDS, the resident scored six out of fifteen on the Brief Interview for Mental Status (BIMS) indicating severe cognitive deficit. The MDS revealed the resident received hospice care while a resident. Review of the Census tab on 06/29/20 indicated on 12/27/19 the resident admitted to hospice medicaid. A review of the MDS tab lacked a significant change assessment MDS completed after admission to hospice care. During an interview on 07/01/20 at 1300 AM, Director of Nursing stated the facility should complete a significant change assessment when a resident admits to hospice.	F 637		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to meet professional standards of quality when following Physician Orders for 1 of 8 residents reviewed. Resident #1's medication administration record (MAR) identified the resident did not receive a Fentanyl patch (pain medication) as ordered and the record lacked documentation of weekly weights as ordered. The facility reported a census of 29 residents.	F 658		

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Findings include:

Resident #1's Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a diagnosis of Amyotrophic Lateral Sclerosis (ALS), chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other dysphagia.

Record review:

The Physician Order Summary dated 6/26/20 showed an order for Fentanyl 75 mcg (micrograms) every three days for pain starting on 6/17/20 and weekly weights starting 2/12/20.

The Medication Administration Record (MAR) dated 6/20/20 lacked documentation of administration for the Fentanyl 75 micrograms (mcg).

On 6/25/20 at 12:18 PM, the Nurses Note showed the hospice staff gave the resident a whirlpool. Upon finishing the whirlpool, the Hospice staff reported removing an outdated pain patch they observed on the resident during the bath. Staff then placed a new Fentanyl Patch on the resident.

On 6/26/20 at 11:20 AM, the Orders - Administration Note showed a Fentanyl Patch 75 mcg patch changed per the nurse's instruction.

The previous thirty-day review of tasks shows a weight of 122 pounds (#) on 6/2/20. The task record lacked any further weights for the month of

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6/20.

The Weight Summary showed the following weights
6/2/20 - 122#
5/21/20 - 124#
4/16/20 - 125.0#
4/2/20 - 125#
3/31/20 - 127.5#
3/19/20 - 127#
3/12/20 - 125#
3/5/20 - 125.5#
2/27/20 - 122.5#
2/20/20 - 121.0#
2/1/20 - 119.5#
1/27/20 - 130#

The care plan problem dated 2/24/20 showed the resident had pain related to ALS and a fracture to the left
ankle. The intervention dated 2/24/20 said to administer analgesia as per orders.

The Hospice progress note dated 6/25/20 indicated the

Interviews:

On 6/29/20 at 11:15 AM, the Hospice Staff # 1, Registered Nurse (RN), reported when she assisted the resident in 6/25/20 that she observed a Fentanyl Patch dated 6/20/20 on the resident. Hospice Staff #1 said the facility charge nurse reported changing the patch that day but then left the room and then reported changing the patch the day before. Hospice Staff #1 stated that the nurse did change the patch while Hospice Staff #1 was at the facility on 6/25/20.

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F 658	Continued From page 15 On 7/1/20 at 1:55 PM, the Director of Nursing (DON) reported the Fentanyl patch not signed for 6/23/20 as the order directed. The count was off for two residents. The DON said she validated the date of the patch on the resident due to a lack of documentation on the MAR. Resident #1 was one of the residents who did not have a correct count for the Fentanyl patches. On 7/1/20 at 1:00 PM, the resident denied noticing an increase in pain the week before. Statement: The statement dated by 7/2/20 by the Administrator and DON noted two of the Fentanyl patch counts were incorrect. Resident #1's narcotic (narc) count sheet showed that the resident should have two patches, and the number of patches in the drawer was three. The Administrator and DON checked Resident #1's patch. The patch was correct with a date of 6/25/20 on the patch. Policies: The Medications - Controlled policy with a revision date of 3/1/14 directed staff to sign out controlled substances at the time of dispensing the medication. Staff should document the medication in the appropriate area of the MAR.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, and staff interviews, the facility failed to provide the necessary services for incontinence care and bathing for 4 of 7 residents reviewed (Residents #1, #2, #5, and #7). The facility reported a census of 29 residents.

Findings include:

1. A Minimum Data Set (MDS) completed for Resident #1 with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had a diagnosis of Amyotrophic Lateral Sclerosis (ALS), chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other dysphagia. The resident was frequently incontinent of bladder and always continent of the bowel. The resident never exhibited a rejection of care in the seven day lookback period, and no change noted in the behaviors since the last assessment.

Interviews:

On 6/29/20 at 10:10 AM, the Resident's Representative reported the resident did not receive changing of her clothes or incontinence brief. The Director of Nursing (DON) stated she would check to ensure staff changed the resident every two hours. The representative received a report from the Hospice staff that the resident was so wet that the brief stuck to the resident at 11:00 AM. The resident reported no one checked her since 5:00 AM. The resident did not receive any baths except bed baths except when the Hospice would come to the facility.

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On 6/29/20 at 10:32 AM, Hospice Staff #4, Registered Nurse (RN), said Hospice regularly found the resident incontinent with the brief sticking to the resident's skin. Hospice would usually visit around 11:00 AM and 1:00 PM. Hospice Staff #4 did not notice any concerns with pressure ulcers. Hospice Staff #4 reported Hospice staff provided a majority of the grooming and baths for the resident. On one visit, the resident had bowel movement dried on to the skin. Hospice staff took the resident to the whirlpool, but it needed cleaning first as it appeared staff used the whirlpool area as central supply. Hospice Staff #4 said the resident could respond appropriately and reported no staff in the room to check on the resident since 5:00 AM.

On 6/29/20 at 10:41 AM, Hospice Staff #5, Manager of Clinical Services, said it was excessively difficult to contact the facility Administration Staff. Hospice Staff #5 attempted in the past without success in reaching them.

On 6/29/20 at 11:15 AM Hospice Staff #2, Certified Nurse Aide (CNA) said the resident is usually completely saturated when she sees the resident at the facility. Today (6/29/20) was the first day Hospice Staff #2 came to the facility and found the resident dry. Hospice Staff #2 reported coming to the facility around 10:30 AM. Hospice Staff #2 had come to the facility for approximately one month. Hospice Staff #1, RN, said the Hospice staff just started to give the resident whirlpools twice a week. The facility only gave the resident bed baths. The resident's skin appeared extremely dry and was flaking off the resident. After the first whirlpool provided by Hospice Staff #2, the whirlpool tub was full of dead skin.

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Hospice Staff #1 said that if the facility was giving the resident bed baths, it was not enough for the resident. The facility was putting A&D ointment into the resident's hair due to cradle cap. The hospice staff needed dawn dish soap to remove the A&D ointment from the resident's hair. It took approximately seven washes to remove the A&D ointment from the resident's hair. The Hospice staff's biggest concern was the resident's incontinence care. Hospice Staff #1 said there were a couple of times the resident wore two briefs. The resident was incontinent through both briefs onto the bed as there was no underpad beneath the resident. The resident reported the staff changed the resident last at 5:00 AM. The Hospice team attempted to contact the facility. Hospice Staff #1 said the Administrator returned a call stating she did not deal with that. The Hospice staff contacted the Director of Nursing (DON) on 6/12/20 about the concerns. Following the conversation with the DON, Hospice Staff #2 came to the facility and observed the resident wearing two briefs saturated with urine through to the bed. There were no reports to Hospice Staff #1 or Hospice Staff #2 regarding the resident refusing any care.

Resident's Interview:

On 6/30/20 at 12:58 PM, the resident said recently she received care. The weekends were not good for getting care. The resident said the night shift was good but then wouldn't change the resident at all. The resident said the facility did not give baths as they expected Hospice staff to do them. Up until last week, it wasn't on the Hospice care plans to do. The resident reported not getting a shower for weeks. The staff just washing the resident up and that's why the

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resident's hair got so bad. The resident heard staff talking about the bath schedule. The resident wasn't on the schedule-the resident reported listening to staff all the time. The resident said her bottom hurt. The resident reported wanting whirlpool baths.

During a follow-up interview on 7/1/20 at 1:00 PM, the resident reported it made her feel sad and degraded when the staff didn't change her or bathe her. The resident said that occasionally she would refuse to change her clothes.

Observation:

On 6/29/20 at 12:44 PM, Staff A, Certified Medication Aide (CMA), and Staff I, Licensed Practical Nurse (LPN), entered the resident's room and explained plan to the resident. The resident utilized the communication board to spell out "wet". Staff A removed the incontinent brief. Staff complete incontinence cares on the resident and then washed their hands. Staff I remained in the room to help the resident get comfortable. Observation showed small brownish-red spots on the left side of the resident's sheet.

On 6/30/20 at 12:58 PM, Hospice Staff #1 and Hospice Staff #2 assisted the resident with incontinence cares. Observation showed the left side of the resident's sheet to have the same reddish-brown spots in the same place as the observation on 6/29/20.

Staff did not offer the resident the bedside commode.

Staff Interview:

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On 7/1/20 at 10:25 AM, Staff A reported not giving the residents baths as they were for the evening shift. Staff A stated Resident #1 received a bed bath in the mornings due to getting sweaty in the night.

During a follow-up interview on 7/1/20 at 1:10 PM, Staff A stated that if the residents were sleeping, she would let them sleep. Staff A said she didn't usually go into the room until the nurse went into the room (usually around 6:30 to 7 a..m.) because she doesn't want to make them do more work. Staff A stated Resident #1 didn't refuse care, but it did cause pain sometimes to change the resident's clothes. Staff A felt it would help the resident to have more adaptive clothing as it causes the resident so much pain. Staff A said that the resident was very particular with the clothes worn and sometimes did not wish to change them. Staff A wasn't sure if the resident refused to change clothes due to pain.

Record review:

On 5/15/20 at 5:36 PM, Hospice Staff #4 documented the resident's niece expressed concern as facility staff didn't change the resident for three days. When asked about this, facility staff reported the resident's clothes were never brought to the resident's room. Documentation showed staff received education on hygiene and resident's dignity by Hospice Staff #4.

On 5/26/20, the Resident Communication Form revealed staff washed the resident's face, provided oral care, and preformed hair care. Then Hospice Staff #2 repositioned, checked, and changed the resident.

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On 5/27/20, the Residential Communication Form revealed staff washed the resident's face, provided oral care, and preformed hair care. Then Hospice Staff #2 repositioned, checked, and changed the resident.

On 5/28/20, the Residential Communication Form revealed staff washed the resident's face, provided oral care, and preformed hair care. Then Hospice Staff #2 repositioned, checked, and changed the resident.

On 5/29/20, the Residential Communication Form revealed staff washed the resident's face. Then Hospice Staff #2 repositioned, checked, and changed the resident.

On 5/29/20, Hospice Progress notes showed Hospice Staff #4 documented she cleaned the resident in bed and provided perineal (peri) cares with brief changed. Hospice repositioned the resident in the bed, washed the resident's face washed and provided oral care.

On 6/1/20, the Residential Communication Form revealed staff washed the resident's face and hands. Then Hospice Staff #2 repositioned, checked, and changed the resident. Staff D, Certified Medication Aide (CMA), came into the resident's room to see if Hospice Staff #2 needed any assistance. Hospice Staff #2 declined the need for help.

On 6/9/20 at 12:38 PM, the Hospice progress note showed the resident received incontinence cares, changing of the resident's gown, teeth brushed, face washed, and a partial bed bath completed. Hospice observed shearing to the resident's buttocks.

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On 6/12/20 at 1:29 PM, a Hospice progress note showed the resident was incontinent of bladder when they arrived. Hospice Staff #1 assisted Hospice Staff #2 with incontinence cares and repositioning of the resident.

On 6/19/20 at 1:44 PM, a Hospice progress note documented the training needs related to the patient's care were medications, side effects, and the dying process reviewed. Hospice provided education to the facility regarding incontinence care and medications. The facility verbalized understanding.

On 6/23/20 at 12:46 PM, Hospice Staff #4 documented the resident's hair as greasy due to the use of A&D ointment for cradle cap. Hospice Staff #2 reported the resident wore the same shirt as the day before. The resident said no staff came into the room from the facility before the Hospice Staff arrived that day to provide care. The resident was incontinent of bowel and bladder and taken to the whirlpool room. The resident's hair was shampooed four times without success in removing ointment. The resident had a significant build-up of skin and dirt on their hands and feet that Hospice scrubbed off. The resident was taken back to their room and put back into the bed with clean linens. Hospice returned the resident back to her room and observed the resident's pillows as very dirty, with yellow and brown stains noted. Hospice placed fresh linens and sent the soiled linens to the laundry. Hospice Staff #4 discussed concerns with facility staff. Hospice Staff #2 provided oral care and lotioned the resident. Hospice Staff #2 notified the Manager of Hospice Clinical Services of concerns.

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On 6/25/20, the Residential Communication Form revealed that the resident received a whirlpool bath with shampoo. They noted the resident with shearing to the coccyx.

On 6/25/20, the Client Coordinator Note Report showed the Hospice Nurse, and Hospice Aide took the resident to the whirlpool room. While there, the Hospice staff gave the resident a whirlpool and cleansed the resident's hair. Due to the excessive amount of A&D ointment in the resident's hair, the staff needed to use Dawn dish soap to wash the resident's hair. They washed the resident's hair three times to successfully clean the hair. The resident's coccyx continued with shearing and Hospice applied ointment to the area. Hospice notified the facility of the area to the coccyx and the need for routine incontinence care. The facility staff verbalized understanding.

A Grievance Form dated 6/25/20 completed by the facility said the Resident's Representative wished to move the resident to another facility. The Resident's Representative explained the request to move was due to things going downhill since May. The Hospice staff reported that the resident's care was poor.

The statement provided from the facility dated 6/25/20 by the Social Services Director documented the call regarding the Resident's Representative's request to change facilities. The Resident's Representative informed the Social Services Director about not being happy with the care provided to the resident. Facility staff did not bathe, change, or check on the resident regularly. The Resident's Representative reported leaving

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voicemails for the DON and the Administrator about the concerns, without improvement. The Resident's Representative said it was the "third strike." The Social Services Director offered to look into this. However, the Resident's Representative declined as wanting to move the resident due to being tired of the situation. The Resident's Representative stressed the frustration of the resident not getting baths. The Social Services Director explained that Hospice was at the facility five days per week. They typically assist or conduct the baths.

On 6/29/20 at 11:35 AM, a Hospice progress note completed as a late entry showed the Hospice Manager of Clinical Services called the DON on 6/24/20 regarding concerns the clinical team reported and to schedule a care conference with the team.

On 6/29/20 at 11:48 AM, a Hospice progress note showed the aide care plan updated to add a whirlpool bath twice weekly. Hospice staff began giving whirlpool baths on 6/23/20.

The bathing task showed that the resident received bath baths on 6/5/20, 6/7/20, 6/8/20, 6/12/20, and 6/17/20. On 6/22/20, the staff documented the resident received a shower. The record shows whirlpools documented for 6/23/20 and 6/25/20.

The care plan problem dated 1/30/20 showed the resident had an activities of daily living (ADL) self-care performance deficit related to ALS, impaired balance and musculoskeletal impairment. An intervention dated 1/30/20 showed the resident required assistance with oral care and personal hygiene. Staff should

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encourage the resident to change clothes daily. An intervention dated 3/8/20 revealed the resident required the assistance of two for toileting and the resident should use a bedside commode. The care plan directed staff to offer toileting upon rising, before and after meals, at bedtime, and as needed upon request.

Administration interviews:

On 7/1/20 at 10:54 AM, the DON reported just learning that the resident's hospice provider did not provide baths. This was the DON's first experience with a Hospice provider not providing baths.

During a follow-up interview on 7/2/20 at 8:45 AM, the DON reported that on 6/15/20, educating staff to make aware that staff was to help the resident.

2. The MDS completed for Resident #2 with an ARD of 4/2/20 showed the resident had short and long-term memory problems and severely impaired decision making. The resident never or rarely made decisions. The resident required extensive assistance of two staff for toileting and total dependence with two staff for bathing. The resident never experienced a rejection of care in the seven day lookback period. The resident was always incontinent of bowel and bladder. The resident had diagnoses of cerebral infarction, adult failure to thrive, aphasia following cerebral infarction.

Observations:

On 6/29/20 at 9:23 AM, observations revealed a slight urine smell near a room in the A Hallway.

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On 6/29/20 at 12:22 PM, observation showed Staff A and Staff I assist the resident with incontinence cares. Staff remove the brief which was full of urine. Urine went through the resident's brief onto the underpad and on to the sheet. The underpad was placed high up on the resident's hips not altogether preventing the leakage of urine on to the bed. As Staff A positioned the resident away Staff I and observation revealed a large area of redness to the resident's right ischium bone. Staff A offered to change the resident's shirt and the resident shook head to decline.

Record review:

The bathing task record showed bed baths completed on 6/1/20 and 6/4/20. The documentation showed the resident refused a bath on 6/3/20 and 6/17/20. The record lacks any further documentation related to baths.

A care plan problem dated 3/12/20 showed the resident had an ADL self-care performance deficit related to hemiplegia (weakness), impaired balance, limited Mobility, and a stroke. An intervention dated 3/12/20 showed that the resident is totally dependent on two staff to provide a shower at least twice a week and as necessary.

Interviews:

On 7/1/20 at 10:25 AM, Staff A reported not giving the residents baths as they do them on the evening shift.

During a follow-up interview on 7/1/20 at 1:10 PM, Staff A stated that if the residents were sleeping,

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she would let them sleep. Staff A said she didn't usually go into the room until the nurse entered the room (usually around 6:30 - 7:00 AM) because she didn't want to make them do more work. Staff A said she often returns in about an hour. She stated the resident doesn't make much noise unless he wants repositioning or incontinent care.

On 7/1/20 at 1:55 PM, the DON said staff needed to document baths in the electronic health record whether given or refused.

During a follow-up interview on 7/2/20 at 10:15 AM, the DON said staff needed to change linens if they are dirty with whatever, feces, or urine.

3. A Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 5/31/20 for Resident #5 shows a Brief Interview Status Score (BIMS) of 6 (severe cognitive impairment). MDS showed Resident #5 with diagnoses that included: Alzheimer's disease, chronic obstructive pulmonary disease, and atrial fibrillation. The MDS revealed the resident required extensive assistance with all activities of daily living (ADL'S)

Review of bath schedules for hall A revealed the bath schedule did not contain Resident #5's name.

Review of the bathing task staff sign off documentation revealed no bathes completed for the prior thirty day look back period.

On 7/1/20 at 7:40 AM Staff A stated the facility did not have a designated bath aid responsible for completing baths as scheduled. Staff A stated when staff completes a bath, staff documents in

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Point Click Care (PCC).

On 7/1/20 at 10:20 AM Staff A revealed Hospice gives Resident #5 a bath, but then stated no the resident is on the bath schedule for Tuesdays and Fridays. Staff A stated she did not know why a bath is not documented and could not state when Resident #5 had their last bath.

4. A MDS with ARD of 5/13/20 for Resident #7 revealed a BIMS of 13 (no cognitive impairment). The MDS showed Resident #7 to have a diagnoses that included: Coronavirus Disease 2019, Chronic Obstructive Pulmonary Disease, and Heart Failure. The MDS revealed the resident required one person physical assistance with bathing and independent with ambulation

A Bath schedule sheet for Hall C revealed the resident scheduled for a bath on Monday and Thursdays.

Review of bathing task staff sign off documentation revealed no baths completed for a thirty day look back period.

On 7/1/20 at 9:15 AM the resident stated he preferred a sponge bath and he required staff to assist with this activity due to receiving continuous oxygen. The resident identified not receiving a bed bath for awhile and no staff have asked if he wanted one or if he completed a bath on his own. A care plan contained an intervention of encourage resident to bath dated 8/16/19.

On 7/1/20 at 10:20 AM Staff A stated the resident gave his own bed bath. Staff only provides towels and staff is to ask the resident if he had

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F 677	Continued From page 29 completed his bath and document in PCC. Review of the facility bath/shower policy dated 3/1/14 revealed residents have the opportunity to bathe at least weekly or as resident request or as needed. On 7/1/20 at 2:00 PM the DON stated she expects residents to bathe one to two times a week and if refused it staff should document that. The DON expected Hospice to help bathe residents but knows the facility should not rely on hospice for all the bathing.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692		

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by:
Based on interviews and record reviews, the facility failed to assess a resident's weight accurately, and appropriately intervene for one of seven residents reviewed (Resident #4). The facility reported a census of 29 residents.

Findings include:

Resident #4's Minimum Data Set (MDS) completed with an Assessment Reference Date of 5/14/20 identified the resident with short and long-term memory problems and severely impaired decision making. The MDS showed a weight loss of 5% or more in the last month or loss of 10% or more over the previous six months, without a prescribed weight-loss regimen. The resident required extensive physical assistance of one staff with eating. The resident had diagnoses that included: cachexia, Alzheimer's disease, and metabolic encephalopathy.

The CAA completed for the 5/14/20 MDS showed a body mass index (BMI) too low as indicated by a BMI of 13.9348.

The resident's Weight Summary showed the following weights
6/1/20 - 67.0 pounds (#)
5/25/20 - 68.0#
5/18/20 - 68.5#
5/11/20 - 83.0#
5/7/20 - 82.0#
5/4/20 - 82.0#
4/27/20 - 85.5#
4/20/20 - 87.5#
4/13/20 - 89.2#
4/8/20 - 88.5#

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F 692	Continued From page 31 3/2/20 - 101.2# 2/1/20 - 100.2# The resident's weight on 3/2/20 showed 101.2#, and on 4/8/20, the resident's weight was 88.5#, indicating a weight loss of 12.7# or a loss of 12.55% in 30 days. The resident's weight on 5/11/20 showed 83.0#, and on 5/18/20, the resident's weight was 68.5#, indicating a weight loss of 12.5# or a loss of 17.47% in seven days. A care plan problem dated 10/15/19 showed the resident at nutritional risk due to having a history of dementia, malnutrition, and anemia. The intervention dated 10/15/19 identified the resident with a history of malnutrition but eating well and with weight stable. No nutritional interventions put in place at the time. The Registered Dietitian (RD) will continue to monitor intakes and weight and put interventions in place as appropriate. On 4/14/20 at 6:11 PM, the Dietary Note showed the resident current weight 89.2#, down 12# (13.5%) in one month and down 7.8# (8.7%) in six months. Intakes varied from 25-100% of meals, and the resident occasionally refused meals. Staff implemented chocolate shakes to help meet nutritional needs. If the resident did not tolerate shakes, 4 ounces of 2Cal (high calorie drink) four times a day recommended to provide approximately 950 calories and 40 grams of protein per day to help meet nutritional needs. Recommend staff encourage intakes at meals as able-RD to monitor intakes and weight. The RD would follow up quarterly or as needed. On 4/29/20 at 3:29 PM, a Nurses Note	F 692		

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documented the Interdisciplinary Team (IDT) team met to discuss the resident's weight. The resident's current weight at 85.5#, down 2.0#. The resident did not eat breakfast and picked at other meals and drank half of her shakes. The resident liked to eat chocolate and the facility should ensure the availability of snacks.

On 5/6/20 at 3:55 PM, a Nurses Note documented the IDT team met to discuss the resident's weight, current weight 82.0, down 3.5# since the 4/29/20 IDT meeting. The resident was of advanced age with advancing dementia and the facility was to contact the family to discuss the end of life options.

On 5/7/20 at 4:11 PM, a progress note completed as a late entry showed the facility received a signed order for a Hospice evaluation due to weight loss and advanced dementia. The facility notified the chosen Hospice agency of the order.

The resident's record lacked documentation of notification to the Physician for the weight loss noted on 4/8/20 until 5/7/20.

The resident's chart lacked documentation related to the Physician's notification regarding the weight loss on 5/18/20.

On 6/10/20 at 10:09 AM, the Care Plan Conference Note lacked documentation related to dietary.

On 7/2/20 at 10:15 AM, the Director of Nursing reported that the IDT meetings were charted in the resident's record once completed. The IDT consisted of facility department heads. If there wasn't an IDT meeting documented, there was no

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F 692	Continued From page 33 meeting. The facility did not have a Registered Dietitian (RD) for approximately one month. The RD should see residents monthly and as needed. The decision for supplementation was based on the individual.	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 725		

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facility failed to assure that there was sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs by answering residents calls lights in a timely manner for three (Resident # 6, #7, and # 1) out of six residents reviewed. The facility reported a census of twenty nine residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date (ARD) of 6/23/20 for Resident #6 revealed a BIMS of 15 (no cognitive impairment). The MDS revealed Resident #6 had diagnoses that included: Coronavirus Disease 2019, Diabetes, and hypertension. The MDS shows Resident to need extensive assistance with all ADL's except for eating.

Call light report for 6/24/20 thru 6/30/20 shows Resident waited 27:47 minutes on 6/24/20, 15:41 minutes on 6/27/20, 17:00 minutes on 6/28/20, 15:15 minutes on 6/29/20, 20:06 minutes on 6/29/20, 20:30 minutes on 6/30/20, 18:20 minutes on 6/30/20, and 15:36 minutes on 6/30/20.

On 06/30/20 at 1:25 PM the resident identified two episodes of bowel incontinence due to having to wait for staff to answer the call light. The resident stated that she had never been incontinent of bowel before.

2. The MDS with ARD of 5/13/20 for Resident #7 revealed a BIMS of 13. The MDS identified the resident with diagnoses that included: Coronavirus Disease 2019, Chronic Obstructive Pulmonary Disease, and Heart Failure. The MDS revealed the resident required one person physical assistance with bathing and independent

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with ambulation. The resident used oxygen continuously.

Call light report for 6/24/20 thru 6/30/20 revealed the resident waited 15:24 minutes on 6/27/20, 18:58 minutes on 6/28/20, 40:17 minutes on 6/29/20, 22:37 minutes on 6/29/20, and 19:56 minutes on 6/30/20.

On 7/1/20 at 9:30 AM the resident stated sometimes it takes staff a long time to answer the call light, and it has been worsen since they moved a lot of residents off of hall C which the resident currently lives on. The resident stated he times the staff to see how long it takes them and looks at the digital clock across from where he is seated. He begins timing it when he activates the call light. The resident stated he fell about six months ago as he got tangled up in the oxygen tubing. The resident stated he pushed the call light when he was on the floor but nobody came so he got up without assistance. Staff came to room and asked what was needed and the resident told them about the fall. The resident stated staff looked him over and determined there no injury occurred. The resident was upset about staff not answering his call light timely and went to the Director of Nursing (DON) to make a complaint and was told it was due to a facility staff shortage. The resident stated he complained to the Certified Nurses Aid (CNA) about how long it took her to answer his light and CNA stated that it was only 10 minutes and the resident informed the CNA it was 30 minutes as he was timing the response.

A post fall review dated 12/10/19 revealed the resident fell and identified the cause as the resident tripped over his oxygen tubing. The

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intervention following the incident was for staff to assist the resident with keeping oxygen tubing out of his walk way. The resident needs to ask for help in keeping tubing picked up and use his call button.

On 7/1/20 at 2:00 PM the DON stated she expects to answer call lights within fifteen minutes. The DON stated she did not do call light audits but looked at the call light report every once in a while. She stated she heard complaints from residents in Hall C and looked into them and there was nothing of concern to her.

3. A MDS completed for Resident #1 with an ARD of 3/25/20 showed a BIMS score of 14, indicating intact cognition. The resident had diagnosis of Amyotrophic Lateral Sclerosis (ALS), chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other dysphagia.

Interviews:

On 6/30/20 at 12:58 PM, the resident said that when the resident was able to push the call light, the staff didn't come to answer the call light.

Care Plan:

A care plan problem dated 1/30/20 showed the resident with an activities of daily (ADL) self-care performance deficit related to ALS, impaired balance, and musculoskeletal impairment. An intervention dated 1/30/20 said to encourage the resident to use the bell to call for assistance.

The review of the call light log showed response times greater than fifteen minutes occurred seven times in from 6/23/20 - 6/30/20.

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6/27/20 at 11:21 AM - 20 minutes and 6 seconds
6/27/20 at 11:56 AM - 27 minutes and 36 seconds
6/27/20 at 12:49 PM - 16 minutes and 51 seconds
6/28/20 at 10:52 AM - 21 minutes and 20 seconds
6/29/20 at 7:52 PM - 18 minutes and 19 seconds
6/29/20 at 8:22 PM - 24 minutes and 40 seconds
6/29/20 at 10:14 PM - 18 minutes and 35 seconds

On 7/1/20 at 10:25 AM, Staff A, Certified Medication Aide (CMA), reported never having issues with something terrible happening due to call light response times. Staff A reported not having trouble with call lights, but the facility was busy. Staff A said it was hard with staffing at the time. Staff A reported that it was not always like that.

On 7/1/20 at 1:55 PM, the DON said she expected staff to answer the call lights in fifteen minutes or less. The DON believed there were times that the response time was greater than fifteen minutes. One of the Department Heads reviewed the call light log. From there concerns are brought to the DON, the DON then reviews it. Occasionally there are times the call light log isn't an accurate response, as sometimes staff forgot to turn off the call light. A couple of residents from the A hall were upset there wasn't staff available to help. The residents in hall C were either independent or an assist of one.

Policy review:

The Resident Call System policy dated 4/1/18 stated that all staff responded promptly when the call system was activated.

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to account for Narcotic Medications for one of one resident reviewed (Resident #1). The facility reported a census of	F 755		

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29 residents.

Findings include:

A Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/20 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident had diagnoses that included: Amyotrophic Lateral Sclerosis (ALS), chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other dysphagia. The resident used opioids for seven of the previous seven days in the lookback period.

Interviews:

On 6/29/20 at 11:15 AM, Hospice Staff # 1, Registered Nurse (RN), reported on 6/25/20 she observed a Fentanyl (narcotic) patch dated 6/20/20 on the resident. Hospice Staff #1 said the nurse reported changing the patch that day but then left the room and later said she changed the patch the day before. Hospice Staff #1 stated the nurse did change the patch while Hospice Staff #1 was at the facility on 6/25/20.

On 7/1/20 at 1:00 PM, the resident denied noticing an increase in pain the week before.

On 7/2/20 at 9:51 AM, Staff D, Certified Medication Aide (CMA), said the staff gave the resident the medication and then they sign off on the Medication Administration Record (MAR) then sign off on the narcotic count record. The staff counts the narcotics at a shift change, with one staff counting the medications and one staff checking the book. Staff D wasn't aware of any issues with the count being wrong. Staff D

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showed that eight residents used narcotic medications in the A hall.

Observations:

On 7/1/20 at 1:35 PM, observation showed the resident with a Fentanyl patch on the left upper arm dated 6/28/20.

Chart review:

A Physician Order Summary dated 6/26/20 revealed a physician order for a Fentanyl 75 mcg (micrograms) Patch every three days for pain starting on 6/17/20.

The MAR dated 6/20/20 lacked documentation of administration for the Fentanyl 75 mcg. Patch.

On 6/25/20 at 12:18 PM, Nurses Notes revealed hospice staff gave the resident a whirlpool. Upon finishing the whirlpool, Hospice staff reported removed an outdated pain patch noted on the resident during the bath. Staff placed a new pain patch on the resident.

On 6/25/20 the Client Coordination Note Report showed the Hospice Nurse observed a patch dated 6/20/20. The Hospice Nurse reported this to the facility nurse. The facility Nurse reported the patch was changed that day just before removing and applying a new patch.

On 6/26/20 at 11:20 AM, the Orders - Administration Note showed a Fentanyl Patch 75 mcg patch changed per the nurse's instruction.

A care plan problem dated 2/24/20 showed the resident had pain related to ALS and a fracture to

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the left ankle. The intervention dated 2/24/20 said to administer analgesia as per orders.

The Verification of Controlled Substance Count sheet for 6/15/20 - 6/26/20 showed missing signatures for the on-coming caregiver for 6/26/20 at 6:00 AM. The narcotic (narc) count showed missing signatures of off-going caregiver for 6/15/20, 6/20/20, and 6/24/20.

The Controlled Substance Record dated 6/23/20 showed documentation of two patches signed by the Administrator and DON. There was no documentation related to the patch documented as given on 6/25/20 per the progress note.

The chart and narcotic count sheets lacked documentation of a patch placement for 6/28/20.

Facility statement:

The statement dated by 7/2/20 by the Administrator and the Director of Nursing (DON) noted two of the Fentanyl patch counts were incorrect. Resident #1's narcotic count sheet showed the resident should have two patches, and the number of patches in the drawer was three. The Administrator and DON checked Resident #1's patch. The patch was correct with a date of 6/25/20 on the patch.

DON interview:

On 7/1/20 at 1:55 PM, the DON reported the Fentanyl patch not signed for the 6/23/20. The count was off for two residents. The DON said she validated the date of the patch on the resident due to a lack of documentation on the MAR. Resident #1 was one of the residents who

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F 755	Continued From page 42 did not have a correct count for the Fentanyl patches. Policy review: The Medications - Controlled policy with a revision date of 3/1/14 showed Scheduled II or higher controlled substances are signed out upon dispensing of the medication. A count of controlled drugs is maintained by nurses of the off-going and on-coming shifts. Any irregularities are to be reported to the Director of Nursing. The controlled documentation procedure stated that a separate controlled substance administration control record is kept on all scheduled II drugs. It contains the amount verifiable by inventory.	F 755		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility did not wear appropriate personal protective equipment (PPE) as indicated by the Iowa Department of Public Health for the prevention of Novel Coronavirus 2019 (COVID-19) throughout the facility. The facility reported a census of 29 residents.

Findings include:

1. On 6/29/20 at 9:21 AM observation revealed two therapists working with a resident. The therapists failed to wear face shields or goggles. They did wear face masks.

2. A Minimum Data Set (MDS) completed for Resident #2 with an Assessment Reference Date (ARD) of 4/2/20 showed the resident had short and long-term memory problems and severely impaired daily decision making. The resident never or rarely made decisions. The resident required extensive assistance of two staff for toileting and total dependence with two staff for bathing. The resident never experienced a rejection of care in the seven day lookback period. The resident was always incontinent of bowel and bladder. The resident had diagnoses that included: cerebral infarction, adult failure to thrive, aphasia following cerebral infarction.

Observation:

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On 6/29/20 at 12:06 PM, observation showed Staff A, Certified Medication Aide (CMA), and Staff I, Licensed Practical Nurse (LPN), completed incontinence cares for the resident. Neither staff wore a face shield or goggles. During the resident's care, Staff A's face mask fell below the staff's nose showing the top of the staff's mouth. Staff A did not reposition the mask until outside of the resident's room at 12:37 PM.

A care plan problem dated 3/17/20 identified the resident at risk for COVID-19 infection with signs and symptoms. The intervention dated 3/17/20 directed staff to follow facility protocol for COVID-19 screening and or precautions.

3. The MDS completed for Resident #3 with an ARD of 6/3/20 showed the resident no memory concerns. The resident could make independent decisions consistently and reliably. The resident had the diagnoses that included: COVID-19, malignant neoplasm of the endometrium, and type II Diabetes Mellitus with other circulatory problems.

Observation:

On 6/29/20 at 12:38 PM, observation showed Staff A and Staff I provide cares to the resident. Neither staff wore the required face shield or goggles during the cares provided. Staff A's mask fell, exposing her nose and a portion of her mouth.

Chart review:

A care plan problem dated 3/17/20 identified the resident at risk for COVID-19 infection with signs

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and symptoms. The intervention dated 3/17/20 said to follow facility protocol for COVID-19 screening and or precautions.

On 5/28/20 at 10:24 AM, a Nurses Note revealed the resident tested positive for the COVID-19 virus. The resident's family notified of results and stated understanding. The resident's primary Physician advised of the results.

On 6/1/20 at 11:25 AM, a Nurses Note showed the Interdisciplinary Team (IDT) met to discuss the resident's COVID-19 status. The resident reported positive on 5/27/20 and was in isolation. The resident said shortness of breath, respiratory rate elevated at 24 on the 14th, and oxygen saturation was greater than 90%. The resident continued on isolation and hospice for endometrial cancer.

The resident's record showed the resident was on droplet precautions from 5/27/20 - 6/22/20 with a private room, and the door closed.

On 6/23/20 at 9:54 PM, the Daily Screener showed the daily screen completed with the following findings:
- Vitals -
Most Recent Temperature: T 97.1 - 6/23/2020 12:55 PM Route: Tympanic
Most Recent O2 Saturation: O2 96.0 % - 6/23/2020 12:55 Method: Oxygen via Nasal Cannula
- Observation Details -
Current Symptoms:
None of the Above / Unknown
Interventions Completed:
Proper PPE Applied / Utilized

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4. A MDS completed with an ARD of 3/25/20 showed a BIMS score of 14, indicating intact cognition. The resident had diagnoses that included: Amyotrophic Lateral Sclerosis (ALS), chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and other dysphagia.

Observation:

On 6/29/20 at 12:43 PM, observation showed Staff A and Staff I provide incontinence cares for the resident. Neither staff wore a face shield or goggles during care.

Chart review:

A care plan problem dated 3/17/20 identified the resident at risk for COVID-19 infection with signs and symptoms. The intervention dated 3/17/20 said to follow facility protocol for COVID-19 screening and or precautions.

Staff interviews:

On 7/1/20, Staff A said staff wore goggles or face shields when the facility had COVID-19, it was a sweat show then. Now the staff only wear the face shield or goggles for the rooms that need them but not every room.

DON interview:

On 7/1/20 at 1:10 PM, the Director of Nursing (DON) said staff should wear full PPE for isolation rooms as posted on the door. The DON said she believed all should have full PPE. Staff should use face protection for direct patient contact. Staff wore full PPE for COVID-19 but now just wears masks.

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5. A MDS completed for Resident #6 with an ARD of 6/23/20 showed a BIMS score of 15, indicating intact cognition. Resident had diagnoses that included: Coronavirus Disease, diabetes, and hypertension.

Review of hospital discharge notes revealed the resident tested positive for Covid on 5/4/20 and 6/9/20 with no follow-up testing showing negative results. The resident admitted to the facility on 6/16/20.

Observation on 6/30/20 at 1:25 PM showed the resident located on Hall C with droplet precaution signs posted on door of the resident's room which directed staff to wear facemask, face shield, gloves, and gown when entering room. Observation showed an isolation cart at doorway and two gowns hanging on hooks outside of room with two face shields hanging on hooks outside of room.

Observation on 6/30/20 at 1:55 PM showed Staff G standing in the resident's room in front of the resident who sat in a recliner. Staff G was within arm's length of the resident. Staff G wore a face shield and face mask and gloves.

Observation on 6/30/20 at 2:10 PM showed Staff G remove her gloves and wash her hands in the reisdent's room bathroom. Staff G then exited the resident room walking down hallway about 100 feet and stated, "I almost ran off with this" (referring to face shield). Staff G removed the face shield and returned it to the hook outside of the resident's room without sanitizing the face shield.

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Observation on 6/30/20 at 2:40 PM showed Staff H standing in the resident's room in front of the resident who sat in a recliner. Staff H was within reach of Resident. Staff H removed his /her gown and placed it on the hook outside of the resident's room and then went back into resident's room with no gown or gloves and closed the door.

On 6/30/20 at 2:42 PM Staff H exited the resident's room wearing a facemask and walked down the hall. Staff H did not sanitize her hands.

On 7/1/20 at 2:00 PM the Director of Nursing stated she expected all staff to follow the proper precautions for infection control.

Document review of COVID-19 new admission plan stated staff should wear N95 or higher or facemask if not available along with eye protection, gloves, and gown when caring for residents.

F 550 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will provide each resident with dignity and respect.

Resident #1 no longer resides at the facility per family request. Discharged on 7/9/2020.

In-service was completed on July 7th and 8th of 2020 with education given related to the treatment of our residents and to meet each resident's needs according to their abilities. Resident's rights were also discussed.

Facility resident advocates were assigned and trained to discussed with their assigned resident's concerns about how the staff is treats them. These will be completed three to five times weekly for 4 weeks. Routine advocates rounds will continue at least three times weekly on-going until IDT team determines systems remain in place.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting related to resident treatment and resident rights.

The Quality Assurance Team will monitor grievances logs and resident's advocacy reports monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 558 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will provide reasonable accommodations to meet resident needs to communicate efficiently.

Resident #1 no longer resides at the facility per family request. Discharged on 7/9/2020.

In-service was completed on July 7th and 8th of 2020 with education given related to meeting each resident's communication needs according to their abilities. Resident's rights were also discussed.

All residents have the potential to be affected by communication deficits. Facility wide audit completed 7/28/2020 and other like residents who were identified to be in need of specialty equipment for communication were assessed and devices implemented.

All new admission will have their social history section C related to communication review, if a new resident is identified as in need of a communication device, the Interdisciplinary team during week at risk meeting, along with therapy will review to ensure the most effective device is implemented if needed.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting related to resident needs for communication.

The Quality Assurance Team will monitor all new admission for completion of section C of the social history related to communication needs monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F580 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will notify the resident representative for change of condition to include significant weight loss

Resident #4 no longer resides at the facility, discharge on 7/20/2020.

In-service was completed on July 7th and 8th of 2020 with education given related to family notification of any change of condition.

Weights will be reviewed weekly and monthly per resident needs by the Interdisciplinary team at weekly clinical risk meeting to identify concerns and monitor for family notifications.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting related to resident change of condition.

The Quality Assurance Team will monitor weights, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 637 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will complete all required MDSs as identified by the RAI.

Resident #5 no longer resides at the facility. A significant change assessment was submitted as a late MDS for the admission to hospice care.

All current residents who receive hospice benefits at the facility were review to ensure that a significant change assessment was completed timely.

The interdisciplinary team will review at the week at risk meeting for residents who are newly admitted to hospice care to ensure that a significant change assessment is opened and/or completed.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting related to a resident significant change related to hospice.

The Quality Assurance Team will monitor need for significant change assessment with hospice admission, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 658 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will meet profession standards of quality when following physician's orders. Medications will be administered or explanation given as to why not administered.

In-service was completed on July 7th and 8th of 2020 with education given related to following a physician's order,

Resident #1 no longer resides at the facility, discharged on 7/9/2020.

All current residents will be monitor through the medication administration audit for missing medication 5 x weekly and addressed by Director of Nursing and/or designee.

The interdisciplinary team will review audits at weekly clinical at-risk meeting to ensure that medications or explanations for administration are completed.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting when concerns are identified for missing medications.

The Quality Assurance Team will monitor missing medication audits, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 677 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is 7/21/2020.

The facility will continue to provide the necessary cares for incontinence and bathing.

In-service was completed on July 7th and 8th of 2020 with education given related to incontinence care and bathing.

Resident # 1 no longer reside at the facility being discharged on 7/9/2020 and # 5 no longer reside at the facility being discharged on 7/20/2020.

Resident # 2 and #7 still reside at the facility, the advocate for these residents were educated to observed with their interactions any signs of incontinence and to discuss if they are asked if needing assistance with bathing.

Facility advocates were assigned to discussed with each of their assigned residents about any concerns with incontinence or bathing schedules. These will be completed three to five times weekly for 4 weeks. Routine advocates rounds will continue at least three times weekly following.

The interdisciplinary team will review audits at weekly clinical at-risk meeting to ensure that resident concerns related to incontinence and bathing schedules are addressed if identified.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting when concerns are identified related to incontinence cares or bathing.

The Quality Assurance Team will monitor identified concerns with incontinence and bathing schedules, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 692 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will monitor resident's weights through the interdisciplinary team and warranted with their condition,

Resident #4 no longer resides at the facility, discharged on 7/9/2020.

In-service was completed on July 7th and 8th of 2020 with education given related to obtaining and monitoring of weights.

Weights will be reviewed weekly and monthly per resident need and physician's order. Physician and family notification and care plan updates will be reviewed, by the Interdisciplinary team at weekly clinical at-risk meeting to identify concerns and monitor for family notifications.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting concerns are identified related to weight monitoring.

The Quality Assurance Team will monitor weight monitoring, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 725 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will ensure that there are sufficient qualified staff to meet the residents needs by answering the call lights in a timely manner,

Resident #1 no longer resides at the facility, discharged on 7/9/2020. Resident # 6 and # 7 are asked with their resident advocate interviews if further concerns exist related to call lights being answered and needs met.

In-service was completed on July 7th and 8th of 2020 with education given related to answering call lights in a timely manner.

Call lights will be reviewed 3-5 times weekly by the Interdisciplinary team to identify any continued concerns and follow up with identified residents by the resident's advocate to identify and address any concerns with call lights.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting related to call lights.

The Quality Assurance Team will monitor call light audits, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 755 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility will account for all resident narcotics that are in the facility.

Resident #1 no longer resides at the facility, discharged on 7/9/2020.

An in-service was held on July 7th and 8th, 2020 and the licensed nurses and certified medication aides were educated on the policy for monitoring controlled narcotics and signing the medication administration sheet and narcotic count sheets.

All current residents receiving a narcotic will be monitor through a daily audit 5 x weekly for missing signatures with narcotic count and review of the missing medication audit for missing signatures for each date, by Director of Nursing and/or designee. Any concerns noted will be addressed with the staff member identified.

The interdisciplinary team will review narcotic control count sheet audits and missing medication audits at clinical week at risk meeting to ensure that narcotic counts are current and are completed.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting when concerns arise related to narcotic counts.

The Quality Assurance Team will monitor narcotic count and missing medication audits, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.

F 880 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as neither an admission nor an agreement by the facility of the facts set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by the provisions of the state and federal law.

Correction date for this deficiency is August 2, 2020.

The facility staff will wear the appropriate personal protective equipment as identified by the Iowa Department of Public health.

In-service was completed on July 7th and 8th of 2020 with education given related to use of personal protective equipment when providing resident cares. Guidelines reflect need for eye and face coverings for all resident encounters. This included the two therapy personnel identified.

Follow-up in-service to be completed by all staff as directed by the Department of Inspections and Appeals for education on PPE lessons, Sparkling surfaces, Clean hands and Keep COVID out through you tube videos. Along with this in-service, staff are required to complete a check-off on handwashing/sanitizing and donning/doffing protective personal equipment.

Resident advocates will monitor staff randomly when completing their rounds 3-5 times weekly to ensure that eye covering and face masks are worn with resident encounters and residents in isolation or presumptive isolation are washing their hands and using the proper personal protective equipment when entering a resident room and removing equipment properly and washing hands when exiting the room

Audits will be completed 3-5 times weekly with staff proficiency checkoff related to the use of personal protective equipment for droplet precaution isolation.

The interdisciplinary team will complete root cause analysis when concerns arise at clinical week at-risk meeting related to personal protective equipment.

The Quality Assurance Team will monitor personal protective equipment check-offs, monthly for three months then quarterly for 4 quarters to ensure systems in place are working and to identify any new problems as they may arise.